PATIENT REGISTRATION/INFORMATION FORM

Last Name: _____ First Name: _____

Middle: _____

Preferred Name: _____

Pharmacy & Location: _____

Referred by: _____

Primary Care Physician_____

Reason for Today's Visit: _____

Date of Birth: ___/____/____ Sex: M or F SS#: _____-_____-_____

Race: □ American Indian/Alaska Native □ Black/African American □ White/Caucasian □ Asian
□ Hawaiian/Pacific Islander □ Other □ Unknown □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Declined

Preferred Language: _____ Marital Status: (circle) S M D W

Local Address: _____

City: _____ State: _____ Zip: _____

Alternate Address: _____

If seasonal address, list dates:_____

□ Home Phone #: _____ □ Work Phone #: _____

□ Cell Phone #: _____ Email Address: _____

Employer's Name: _____

I authorize AGI Care to contact PATIENT at email address □ Yes □ No

Persons to whom we may release information:

I authorize AIGI Care to share Patient Medical _____Billing_____ information with the following individual:

PRINT Name_____

Relationship to patient_____

EMERGENCY CONTACT: _____Phone #: _____

Relationship: _____

INSURANCE INFORMATION

Responsible Party (if different than Patient)

Last Name: _____ First Name: _____

Middle Initial: _____

Local Address: _____Apt #: ____ City: _____ State: _____

Zip: _____

Date of Birth: ____/____/____ Phone: _____ Email: _____

Relationship to Patient _____

Primary Insurance

Policy Holder's Name: _____ DOB: ____/____/____

Plan Name: _____ Group Name: _____

Group #: _____

Member ID #: _____

Coverage Type: □ Self □ Family dependent □ Handicapped dependent □ Sponsored dependent
□ Injured plaintiff □Student □ Part-time student □ Full-time student

Secondary Insurance

Policy Holder's Name: _____ DOB: ____/____/____

Relationship to Patient: _____

Plan Name: _____ Group Name: _____

Group #: _____

Member ID #: _____

Assignment and Authorization of Benefits: I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing. I hereby authorize AIGI Care LLC to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to AIGI Care LLC (or the party who accepts assignment). I certify that the information I have reported concerning my insurance coverage is correct. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services provided on my behalf or my dependents. I agree to pay any reasonable collection fees, including reasonable attorney fees necessary to collect my debt.

Patient or Responsible Party Signature:

_____ Date: _____