PATIENT INFORMATION FORM

Cigna Medical Group

Check one of the following:
Attach copy of front and back of Insurance card

- ☐ All CIGNA Insurance
- ☐ Other Insurance (Any Non-CIGNA)
- ☐ FFS/Self Pay

PATIENT INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY #	DATE OF BIRTH	SEX M F
STREET ADDRESS	CITY	STATE	ZIP CODE	PATIENT PHONE
RESPONSIBLE PARTY	RELATIONSHIP TO RESPONSIBLE PARTY	PATIENT E-MAIL ADDRESS		
RESPONSIBLE PARTY STREET ADDRESS	CITY	STATE	ZIP CODE	RESPONSIBLE PARTY PHONE

INSURANCE COVERAGE/OWNER OF INSURANCE POLICY

LAST NAME FIRST NAME M.I.	DOB	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER	EMPLOYER ADDRESS *(STREET, CITY, STATE, ZIP CODE)*		
WORK PHONE ( )	HOME PHONE ( )	INSURANCE CARRIER*	
INSURANCE CO. ADDRESS	INSURANCE CO. PHONE	POLICY ID #	GROUP #

Is the patient covered under any other health coverage? ☐ **Yes** ☐ **No** **If Yes, complete Additional Healthcare Insurance.**

ADDITIONAL HEALTHCARE INSURANCE (Medicare Part B - FFS, Supplemental, All Other Insurance)

LAST NAME FIRST NAME M.I.	DOB	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER	EMPLOYER ADDRESS *(STREET, CITY, STATE, ZIP CODE)*		
WORK PHONE ( )	HOME PHONE ( )	INSURANCE CARRIER*	
INSURANCE CO. ADDRESS	INSURANCE CO. PHONE	POLICY ID #	GROUP #

IN CASE OF EMERGENCY CONTACT

LAST NAME FIRST M.I.	RELATIONSHIP	TELEPHONE #

Your signature below indicates:

1. (If you have insurance) You authorize Cigna Medical Group (CMG) to release medical or other information as requested by your insurance company to have your medical claims paid.
2. (If you have insurance) You authorize direct payment of medical benefits by your insurance company to CMG for any services furnished to you and otherwise payable to you.
3. Your agreement to pay any and all final balance due to CMG for services you receive which are your responsibility and/or are denied by your insurance company.

Patient/Parent or Legal Guardian Signature ______________________ Date ____________

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