Internal Medicine Group
2301 House Avenue, Suite 300
Cheyenne, WY 82001
Fax 307-638-2656 Phone 307-635-4141 www.imgwy.com

Form A

Patient Information

Today's Date _____

Patient Name_____
First M I Last

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Cell _____

As a service to our clients, we provide a courtesy appointment reminder call that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Social Security _____ Date of Birth _____ Age _____ Gender: ☐ M ☐ F

E-mail address _____

Marital Status:	Race:	Ethnicity:	Primary Language:
__Single __Married __Divorced __Widowed	__American Indian/Alaskan Native __Black or African American __Native Hawaiian or Pacific Island __Caucasian __Multi-racial __Other_____	__Hispanic/Latino __Non-Hispanic/Non-Latino __Other_____	__English __Spanish __French __Other_____
Primary Caregiver: __Self __Other_____	Are you deaf? __Yes __No Are you blind? __Yes __No	Advanced Directive: __Yes __No	Do you need a translator? __Yes __No

Employer _____ Occupation _____Telephone _____

Authorized Parties to Speak with Regarding your Billing: _____

Party Responsible for Payment (If other than the patient):

Name _____ Social Security _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Cell _____

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Form A

Patient Name_____

Date of Birth_____

Insurance Information:

Primary Insurance _____ Insurance Phone _____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Please specify) _____

Name of Subscriber _____ Date of Birth _____ Social Security _____

Member ID _____ Group _____ Effective Date _____

Claims Billing Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Insurance Phone _____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Please specify) _____

Name of Subscriber _____ Date of Birth _____ Social Security _____

Member ID _____ Group _____ Effective Date _____

Claims Billing Address _____ City _____ State _____ Zip _____

Emergency Contact Information:

Name _____ Relationship _____

Telephone Home _____ Work _____ Cell _____

How did you learn about Internal Medicine Group? _____

Referred by _____

I hereby authorize medical treatment of the above named patient and agree to be financially responsible for all charges for such treatment, including costs of collection and legal fees (if applicable.) I hereby assign payments to Internal Medicine Group. I authorize Internal Medicine Group to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a late date.

Patient/ Parent/Guardian Signature _____ Date _____