Lorraine M. Dodson, M.D.
Brian T. Stephens, M.D.
Brandi Nichols, M.D.

Women's Clinic of JCMG

Jodi A. Berendzen, M.D.
Amanda T. Rodemann, D.O.

PATIENT REGISTRATION PLEASE PRINT!

DR. _____

APPT. DATE _____

PRIMARY CARE PHYSICIAN _____

PATIENT NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: (___)_____ CELL PHONE: (___)_____ PATIENT'S SOC.SEC. # ____-____-____ DATE of BIRTH: ___-___-___

MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widowed

PATIENT'S EMPLOYER: _____ADDRESS: _____

WORK PHONE: (___) _____ EXTENSIONS _____ OCCUPATION: _____

Email address: _____

SPOUSE'S INFORMATION

SPOUSE: _____ CELL #: (___) _____SOC. SEC. # ____-____-____ BIRTH ___-___-___

SPOUSE'S EMPLOYER: _____ WORK PHONE: (___) _____

EMERGENCY CONTACT PERSON

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (___) _____CELL PHONE: (___) _____WORK PHONE: (___) _____

PLEASE FILL OUT THIS SECTION IF INSURANCE POLICY HOLDER IS OTHER THAN PATIENT.

NAME: _____ SOC. SEC. # _____-_____-_____

ADDRESS: _____

HOME PHONE #: (___) _____ BIRTHDATE: _____ HOW RELATED: _____

EMPLOYER: _____ WORK PHONE #: _____

AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Relations pertaining to Medicare/Medicaid assignment of benefits apply. I understand that I am financially responsible for all charges not covered by this authorization.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR:

X_____ DATE: _____