Dr. Gail Jackson

PATIENT INTRODUCTION

Name ________________________________ Date of Birth_____/_____/_____
Social Security#_______-_______-_______
Address ______________________________
City_____________ State _____ Zip _______

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How may we contact you: May we leave a message?

Cell: ______________________________Message: Yes _____ No _____
Work: ____________________________Message: Yes_____No_____
Home: ___________________________Message: Yes _____No_____
Other:_____________________________Message: Yes_____No _____

Email Address:____

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Who may we thank for your referral? ______________________________________

In CASE OF EMERGENCY PLEASE NOTIFY: ____________________________________

Relationship to patient _________________________ Phone# (____)_____-_______

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AUTHORIZATION AND ASSIGNMENT: I hereby authorize Gail N. Jackson, M.D. to furnish information to insurance carriers concerning my illness and treatments. And I hereby assign to the doctor, all payments for medical services rendered.

- I authorize the office of Gail N. Jackson, M.D. to contact me via SMS
- I authorize the office of Gail N. Jackson, M.D. to contact me via email
- I authorize the office of Gail N. Jackson, M.D. to leave voice messages on my phone

SIGNATURE ______________________________________DATE _______/_______/_______