Cheryl L. Hodges, M.D.

Board Certified General Psychiatrist

TRANSCRANIAL MAGNETIC STIMULATION CENTER OF ALASKA

GENERAL PSYCHIATRY

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(907) 357-9920 Ph (907) 357-9921 Fax

Patient Data

PATIENT INFORMATION

REFERRED BY_____ Today's Date _____

Name _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone_____ Work Phone _____

May we leave messages -- at home? ☐Yes ☐No *on your cell phone?* ☐Yes ☐No *at work?* ☐Yes ☐No

Sex: Male / Female Marital Status: Single Married Widowed Separated Divorced

Date of Birth _____ Social Security #_____ - _____ - _____

Occupation _____Employed by _____

PARENT/GUARDIAN/RESPONSIBLE PARTY

Name of Spouse
Or Parent (if child) _____ Date of birth_____

Occupation _____ Employed by _____

PRIMARY INSURANCE

Policy Holder _____ Relationship to patient_____

Policy Holder's Date of Birth_____ Employer_____

Insurance Company _____ Phone #_____

Group # _____ ID # _____

For **TRICARE patients** provide the Active Service Member's Social Security# _____

SECONDARY INSURANCE

Policy Holder _____ Relationship to patient_____

Policy Holder's Date of Birth_____ Employer_____

Insurance Company _____ Phone #_____

Group # _____ ID # _____

AUTHORIZATION

I hereby authorize my insurance benefits to be paid directly to Cheryl Hodges, M.D., knowing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to the insurance carriers and the billing agency utilized by Dr. Hodges in order to bill my insurance company(s).

SIGNATURE_____ DATE_____