Dennis Jordanides, M.D.
Diplomate, American Board of Internal Medicine

Member Registration

Name: _____ Date of Birth: _____

Gender: ☐Male ☐Female Marital Status: _____ Religion: _____ Ethnicity: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____

Date of Retirement: _____ Occupation: _____

(IF APPLICABLE)

Emergency Contact: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I hereby give consent to contact the above-mentioned individual if I cannot be reached. I further give my consent for any treating physician or physician's representative to speak with this person regarding me, or my medical condition including but not limited to lab/pathology/diagnostic test results.

Signature: _____ Date: _____

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