## welcome to our office

**SHEILA JENKINS, Ph.D.**

# psychologist

(713) 266-9837

Fax to **713-266-9838** or Email to **drjenkins@drsheilajenkins.com**

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| ***Thank you for choosing our office.*** *In order to serve you properly we will need the following information. All information will be strictly confidential.* |
| **Today’s Date:**      | **Patient is:** **[ ]  Child** **[ ]  Adult** |
| **[ ]  Male** **[ ]  Female** |
| PATIENT INFORMATION |
| **Patient’s name:**      | **Age:**   | **Birth date:**  **/**  **/**     |
| **Home address:**      | **City:**      | **State:**      | **Zip:**      |
| **Preferred contact #:****[ ]  Cell** **[ ]  Home** | **Cell Phone:**      | **Home Phone:**        |
| **Social Security number:**   **-**  **-**     | **Occupation:**      | **Personal Email:**      |
| **How do you intend to pay (please check one box):****[ ]  Cash** **[ ]  Check** **[ ]  Insurance** **[ ]  Medicare** **[ ]  Medicaid** **[ ]  Agency** |
| **If patient is a child, what is the parent’s name or guardian’s name:**      |
| INSURANCE INFORMATION |
| *(Please give your insurance card to the receptionist.)* |
| **Is this patient covered by insurance?** **[ ]  Yes** **[ ]  No** |
| **Subscriber’s name:**      | **Address (if different than patient):**      | **Home Phone Number:**      |
| **Employer:**      | **Subscriber’s SS#:**   -  -     | **Birth date:**  **/**  **/**     |
| **Insurance Company Name:**      |
| **Policy/Member ID number:**      | **Group number:**      | **Insurance phone number:**       |
| **Patient’s relationship to subscriber:** **[ ]  Self** **[ ]  Spouse** **[ ]  Child** **[ ]  Other** |
| IN CASE OF EMERGENCY |
| **Nearest friend or relative (not living with you):**      | **Relationship to patient:**      | **Phone number:**      |
| ***I authorize my insurance benefits be paid directly to Dr. Sheila Jenkins. I also authorize Dr. Sheila Jenkins to release any information to expedite my insurance claims. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, regardless of insurance coverage.*** |
| **Patient/Guardian signature:** | **Date:** |