Print Form

Clear Form

**WELCOME TO OUR OFFICE**


**SHEILA JENKINS, Ph.D.**
**PSYCHOLOGIST**
(713) 266-9837

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


***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**

| | | |
|---|---|---|
| **Name of 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:*** |