## welcome to our office

**SHEILA JENKINS, Ph.D.**

# psychologist

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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:** | | | | | |