Dr. Maritza O. Jenkins, DMD 3823 East Morgan Ave. Evansville, IN 47715 812-474-1020
www.Drjenkinsdentist.com

PATIENT INFORMATION

Please complete the following information:

ATTENDING DENTIST: M. O. JENKINS, D.M.D 3823 E. MORGAN AVE. EVANSVILLE, IN 47715	LAST NAME	FIRST NAME MI	PREFERRED NAME
DATE OF BIRTH	PATIENT'S SS #	ADDRESS	CITY
STATE	ZIP CODE	EMAIL ADDRESS	
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -	SPOUSE'S NAME
PATIENT EMPLOYER	ADDRESS	CITY, STATE	ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	PLAN NAME	GROUP #
SUBSCRIBER NAME	INSURANCE ID# / SUBSCRIBER'S SS #	SUSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE COMPANY	PLAN NAME	GROUP #
SUBSCRIBER NAME	INSURANCE ID# / SUBSCRIBER'S SS #	SUSCRIBER'S DATE OF BIRTH

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____
EMERGENCY CONTACT _____ **PHONE #** _____

OFFICE POLICY

It is the policy of this office to make complete payment arrangements at the time of service of the office visit. If you are here for a consultation, payment for the initial exam and any diagnostic x-rays is expected today. Any fees for treatment will be discussed with you. We encourage frank discussion of services and fees prior to treatment in order to avoid any misunderstanding. However, you are responsible for any copays or procedures not covered when that service is rendered. In addition to cash, we also accept credit cards. **PAYMENT IS EXPECTED IN FULL WHEN SERVICES ARE RENDERED .** Accounts not paid within 30 days are considered delinquent and will be forwarded for immediate collection. You will be responsible for any collection, court, attorney and legal fees. There will be an annual interest rate of 24% on all unpaid accounts. There is a $35.00 fee for returned checks.

All information is strictly confidential and is the property of this office. We will not release any records without a **written authorization**. Please allow **48 hours** after the receipt of the completed form for processing. I acknowledge I have **RECEIVED** a copy of this offices's **NOTICE OF PRIVACY PRACTICES**.

Signature _____ **Date** _____ **Self Parent Guardian**

How would you like to pay for services today? Cash____Credit Card ____
(On your first visit, payment ONLY with cash or credit cards.)

APPOINTMENTS: If you need to reschedule your appointment, please give us **48 hours** notice. No-calls or no-shows will be **billed $40** per patient.

This is to certify that I _____ **accept full responsibility for all charges incurred by** _____ **for diagnostic/examination/procedures performed by Dr. M. O. Jenkins or associates.**

Signature _____ **Date** _____ **Self Parent Guardian**