PATIENT INFORMATION

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

PRIMARY DENTAL INSURANCE	SUBSCRIBER EMPLOYER		GROUP #
SUBSCRIBER NAME	SUBSCRIBER'S SS #	INSURANCE ID #	SUBSCRIBER DOB
SECONDARY DENTAL INSURANCE	SUBSCRIBER EMPLOYER		GROUP #
SUBSCRIBER NAME	SUBSCRIBER'S SS #	INSURANCE ID #	SUBSCRIBER DOB

WHO MAY WE THANK FOR REFERRING YOU TO THE 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 x-rays is expected today. We encourage frank discussion of services and fees prior to treatment in order to avoid any misunderstanding. You are responsible for any co-pays or procedures not covered when services are rendered. In addition to cash, we accept credit cards. **PAYMENT IS EXPECTED IN FULL WHEN SERVICES ARE RENDERED.**

How will you pay for services today? (On your first visit, payment ONLY with cash or credit card) Cash____Credit Card ____

Accounts not paid within 30 days are considered delinquent and will be sent 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 unpaid accounts. **ATTENTION:** If your check is returned for insufficient funds, you expressly authorize your account to be electronically debited for the amount of the check plus all fees. The use of a check is your acknowledgement and acceptance of this policy and its terms and condition. **Please Initial** _____

I consent to: This dental practice, or its service provider, may contact me via email or text to provide healthcare information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or pre-recorded voice or telephone equipment that may be capable of automatic dialing. **Please Initial** _____

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.

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 office's **NOTICE OF PRIVACY PRACTICES**.

Signature _____ **Date** _____ **Self Parent Guardian (Circle one)**

***Please, **no cell phones** allowed in treatment areas as it interferes with patient treatment. **Please Initial** _____

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**