WELCOME TO OUR OFFICE

Jonathan M. Jenkins, D.D.S., M.S.

So that we may process your account and/or insurance correctly, please complete this patient account registration form.

PATIENT INFORMATION

NAME: _____

BIRTHDATE: ___/___/___ AGE: _____

SEX: M ❑ F ❑ MARITAL STATUS: _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

OCCUPATION: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

CELL PHONE: ( ) _____

EMAIL: _____

Would you like to receive appointment reminders via email

Yes ❑ No ❑

EMPLOYER _____

EMERGENCY CONTACT NAME _____

PHONE: ( ) _____

RESPONSIBLE PARTY

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS _____
(if different from above)

CITY _____

STATE _____ ZIP _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

CELL PHONE: ( ) _____

PRIMARY INSURANCE

EMPLOYEE NAME _____

EMPLOYER NAME _____

INSURANCE COMPANY _____

GROUP NUMBER _____

MEMBER ID# _____

EMPLOYEE DATE OF BIRTH ___/___/___

EMPLOYEE SS#: _____

SECONDARY INSURANCE

(please fill out if no insurance card available)

EMPLOYEE NAME _____

EMPLOYER NAME _____

INSURANCE COMPANY _____

GROUP NUMBER _____

MEMBER ID# _____

EMPLOYEE DATE OF BIRTH ___/___/___

EMPLOYEE SS#: _____

I give permission for Dr. Jonathan M. Jenkins, DDS, MS to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. I authorize payment directly to Dr. Jonathan Jenkins for insurance benefits.

Patient's or Responsible Party's Signature _____ Date: ___/___/___