

PEDIATRIC NEUROLOGY OF DALLAS

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Please Complete this Page and Bring to your Appointment

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ INITIAL ____ NICKNAME _____

SEX _____ BIRTH DATE _____ SSN# _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTRY _____

FATHER'S NAME _____ DOB _____ HOME # _____ CELL # _____

ADDRESS *(if different)* _____ CITY _____ STATE _____ ZIP _____ SSN# _____

FATHER'S EMPLOYER _____ WORK PHONE _____

MOTHER'S NAME _____ DOB _____ HOME # _____ CELL # _____

ADDRESS *(if different)* _____ CITY _____ STATE _____ ZIP _____ SSN# _____

MOTHER'S EMPLOYER _____ WORK PHONE _____

LEGAL GUARDIAN *(if different from above)* _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTRY _____

EMERGENCY CONTACT (**OTHER THAN PARENT**) _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTRY _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTRY _____

INSURANCE CO _____ INSURED _____

DOB *(if different from above)* _____ ID# _____ GROUP # _____

PHARMACY _____ ADDRESS _____

I UNDERSTAND PEDIATRIC NEUROLOGY OF DALLAS DOES NOT ACCEPT MEDICAID.

I AUTHORIZE **PND** TO DISCLOSE/PROVIDE INFORMATION AT ANY OF THE PHONE NUMBERS LISTED BELOW.

I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY OF ANY CHANGE IN THESE NUMBERS.

BY SIGNING BELOW, I UNDERSTAND **PND** IS AUTHORIZED TO LEAVE A MESSAGE IF I CANNOT BE REACHED DIRECTLY.

I AUTHORIZE **PND** TO DISCLOSE THE FOLLOWING PROTECTED INFORMATION TO THE NUMBERS INDICATED BELOW: LAB RESULTS, TEST RESULTS, APPOINTMENT REMINDERS, PROCEDURES AND OTHER HEALTHCARE SERVICES.

LIST IN ORDER OF PRIORITY WHICH NUMBER WE CAN CONTACT YOU AND/OR LEAVE A MESSAGE

PREFERRED CONTACT MOM _____ HOME _____ WORK _____ CELL
 DAD _____ HOME _____ WORK _____ CELL

SIGNATURE _____

DATE _____

**BRING YOUR REFERRAL AND INSURANCE CARD OR A COPY
 OF INSURANCE INFORMATION TO EACH APPOINTMENT**

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