PEDIATRIC NEUROLOGY OF DALLAS
Mahshid Moein, M.D.
7777 Forest LN, Suite A-317 Dallas, TX 75230
972/566-5656 Fax 972/566-5627

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