NORTH DALLAS CHILDREN'S CLINIC

MUHAMMAD O. MAJEED, M.D. F.A.A.P.

PATIENT INFORMATION

Patient's Last Name First Middle

Date of Birth (MM/DD/YYYY): / / SSN:

Street Address: APT#:

City: State: Zip:

Phone: (H): (C):

Emergency contact name: Phone:

PARENT/GUARDIAN INFORMATION

Relationship to Patient: Relationship to Patient

Last name First Middle Last name First Middle

Date of Birth (MM/DD/YYYY): / / Date of Birth (MM/DD/YYYY): / /

SSN: SSN:

Email: Email:

INSURANCE INFORMATION

Insurance Company:

Medicaid: (Y/N) If Yes, Program Name:

Policy Holder/Insured Name: ID#/Policy#: Group#:

Insurance Phone: Copay:

Claims Address: City: State: Zip:

PHARMACY INFORMATION

Pharmacy Name: Phone#:

Pharmacy Address:

ASSIGNMENT RELEASE:

I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE DR. MUHAMMAD O. MAJEED M.D, TO DIAGNOSE AND TREAT MY CHILD AS INDICATED. I ASSIGN ALL INSURANCE BENEFITS TO DR. MUHAMMAD O. MAJEED, M.D. AND AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCURE PAYMENT FOR SERVICE RENDERED. I AUTHORIZE THE USE OF MY SIGNATURE BELOW ON ALL INSURANCE CLAIM SUBMISSIONS. I ALSO UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR CHARGES TODAY REGARDLESS OF INSURANCE COVERAGE AND AGREE TO PAY ALL CHARGES IN FULL SHOULD MY CLAIM BE DENIED FOR ANY REASON.

PARENT/GUARDIAN SIGNATURE: DATE: