Dallas Pediatrics & ID Associates 1120 S. Main Street, Suite 100, Grapevine, Texas 76051 817-416-5554, 817-416-5556 (fax)

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (*First, M.I., Last):*

Date of Birth: Age: Sex: Male / Female

Address:

(Street) (City) (State) (ZIP)

Phone #: Social Security #: Driver's License #:

Work #: Employer:

Employer's Address:

Referring Physician: If Student, School Name: **How did you hear about us?**

RESPONSIBLE PARTY OR PARENT INFORMATION

Name: Relationship to Patient:

Address: Home Phone #:

Cell Phone #: Social Security #: Driver's License #:

Employer: Work #:

Employer's Address:

Emergency Contact:

INSURANCE INFORMATION

Insurance Co.: Phone #:

Insurance Address:

Group #: Certificate or ID #:

Insured's Name: Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: Phone #:

Employer's Address:

Insured's Social Security #: Date of Birth: Sex: Male / Female

I hereby assign, transfer, and set over to Faryal Ghaffar MD and Dallas Ped & ID Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Parent / Guardian Signature Date