Hales Pediatrics
PATIENT INFORMATION

DATE: _____

Patient's Name:_____

Date of Birth:_____ Sex:_____

Home Address:_____

City:_____State:_____Zip:_____

Best Contact #: ( )_____

BILLING NAME & ADDRESS: ❑ Same as Above

_____

_____

_____

Parents' Marital Status:

❑ Married ❑ Divorced ❑ Separated ❑ Other_____

INSURANCE INFORMATION

SELF PAY ❑ Yes ❑ No If yes, I agree to the terms below.
As a "self pay" patient, I agree to pay the charges as billed by Hales Pediatrics and will not submit charges to any other available coverage.

Signature _____

PRIMARY INSURANCE:

Insurance Plan Name:_____

Member ID#:_____

Group ID#: _____

SUBSCRIBER: _____

Relationship to Patient: _____

Date of Birth:_____ SS #:_____

Address: (If different from above) _____

_____

Telephone#: _____

SECONDARY INSURANCE:

Insurance Plan Name:_____

Member ID#:_____

Group ID#: _____

SUBSCRIBER:_____

Relationship to Patient: _____

Date of Birth:_____ SS #:_____

Address: (If different from above) _____

_____

Telephone#: _____

FOR OFFICE USE ONLY
If all information is correct, please initial and date.

_____ _____

_____ _____

Parent/Legal Guardian:_____

Relationship to Patient: _____

Date of Birth:_____ SS #:_____

Employer's Name:_____

Work Phone: _____

Other Phone (cell, other): _____

Parent/Legal Guardian:_____

Relationship to Patient: _____

Date of Birth:_____ SS #:_____

Employer's Name:_____

Work Phone: _____

Other Phone (cell, other): _____

As a courtesy, our office will file medical claims with your insurance carrier.

I authorize the release of medical or other information necessary to process these claims. I also request payment of government and provider benefits to the party whom accepts assignment below. I authorize payment of medical benefits to the undersigned physicians for services rendered. In addition, I will ultimately be responsible for fees for services provided either personally and/or through insurance coverage. I understand that it is my responsibility to confirm with my insurance company that any recommended laboratory, ER, hospital, and/or specialists are covered under my plan.

CONSENT FOR TREATMENT

I give my consent for Hales Pediatrics physicians to evaluate, examine and treat my child(ren).

_____

Signature of parent, guardian, or patient over 18 years old **Date**

_____

Print Name **Relationship to Patient**

I understand that at times I may not be able to attend my child's visit. I authorize the following individuals to provide consent for evaluation, treatment, and appropriate immunization(s) of my child(ren) on my behalf.

_____

Print Name/Relationship to patient **Initial/Date**

_____

Print Name/Relationship to patient **Initial/Date**