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

____

____

____

ETHNICITY: ❑ Hispanic ❑ Non-Hispanic

RACE:
❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native
❑ Native Hawaiian or other Pacific Islander ❑ 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#: ______________________

PLEASE PRINT LEGIBLY

Parent/Legal Guardian: ______________________

Relationship to Patient: ______________________

Date of Birth: ______________ SS #: ______________

Employer's Name: ______________________

Contact #: ______________________

Email Address: ______________________

Parent/Legal Guardian: ______________________

Relationship to Patient: ______________________

Date of Birth: ______________ SS #: ______________

Employer's Name: ______________________

Contact #: ______________________

Email Address: ______________________

Parents' Marital Status:

❑ Married ❑ Divorced ❑ Separated ❑ 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**

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

______________ ______________

______________ ______________