purePEDIATRICS

Rev. 11/15

Patient _____ Sex _____ Date _____
Last First Middle

Responsible Party _____
Last First Middle

Address _____
City State Zip

Date of Birth _____/_____/_____ SSN _____-_____-_____ Phone_____ Cell_____

Work _____ Employer _____ PCP_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT CHECK IN)

Primary Ins Name _____ Secondary Ins Name _____

Ins Address _____ Ins Address _____

Name Insured _____ Name Insured _____

Insured's ID# _____ Insured's ID# _____

Group# _____ Group# _____

Relationship to Patient _____ Relationship to Patient _____

1. In case of Emergency, who should be notified? _____ Phone _____

2. Who referred you to us? _____

3. **May we contact you via Email? YES or NO EMAIL ADDRESS** _____

4. Patients of VIPediatRx have the right of patient confidentiality on all medical information and test results. All information shall be held in confidence and shall not be disclosed to any person, except upon the expressed consent of the patient or by the guidelines of his/her medical insurance. All reports will only be given to patient unless otherwise noted below. If the patient is a minor, all information will be explained to the patient or legal guardian.

Name of Person whom we may speak with about your care _____

5. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescription. I also authorize payment of medical benefits to the physician. I understand that VIPediatRx does not accept insurance and will only bill out of network, and I am responsible for any remaining balance.

6. I consent to treatment as necessary or desirable to the care of the patient named above, including whatever drugs, medicine, performance of tests, conduct of laboratory, or other studies that may be used by the attending doctor, her nurse or qualified designate. I acknowledge and understand that I am ultimately responsible for all charges and services rendered to me.

7. I have reviewed the office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient/Guardian Signature _____ Date _____