HEMATOLOGY

Patient ____ Sex _________ Date _________
Last Fist Middle

Date of Birth ____/____/____ SSN ______-______-______ Phone____________ PCP________________

Responsible Party ____
Last First Middle

Date of Birth ____/____/____ SSN ______-______-______ Phone ______________________

Address ____
City State Zip

Cell____________________ Work ___________________ Employer ____________________________

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT CHECK IN)

Primary Ins Name ________________________ Primary Ins Name ___________________________

Ins Address _____________________________ Ins Address ________________________________

Name Insured ___________________________ Name Insured ______________________________

Insured's ID# ____________________________ Insured's ID# ______________________________

Group# ________________________________ Group# ___________________________________

Relationship to Patient ___________________ Relationship to Patient _______________________

Insurance Claims Number __________________ Insurance Claims Number _____________________

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 **pure**PEDIATRICS 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 **purePEDIATRICS** 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.

Patient/Guardian Signature ____ **Date** ________________