Hall Medical

Patient Information

First Name_____ **Date of Birth**____/____/____

Last Name_____**Social Security No.**____-____-____

Address_____

City_____**State**_____**Zip Code**_____

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____

Best Number to Reach You? _____

Email:_____

Sex: Male Female

Marital Status: Single Married Divorced Widowed Separated Partner

Emergency Contact

Name_____

Relationship to Patient_____

Address_____

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____

Race: ___Asian ___Black or African American ___White ___Other

Ethnicity: ___Not Hispanic ___Hispanic, Latino/a ___Other

Language Preference: ___English ___Other

Hall Medical

Primary Insurance

Name of Insurance Company_____

Claim Address_____

Policy/ ID No._____**Group No.**_____

Policy Holder Name_____
Policy Holder's Date of Birth_____/____/_____
Relationship to Patient_____

Policy Holder's Address_____

Employer_____

Policy Holder's Social Security No. (required)_____-_____-_____

Secondary Insurance

Name of Insurance Company_____

Claim Address_____

Policy/ ID No_____**Group No**_____

Policy Holder Name_____
Policy Holder's Date of Birth _____/_____/_____
Relationship to Patient_____

Policy Holder's Address_____

Employer_____

Policy Holder's Social Security No. (Required) _____-_____-_____

Hall Medical

Person Responsible for Bills (if different than patient)

Name_____

Relationship to Patient_____

Address_____

Phone (____) _____-_____ **Cell** (____)_____-_____

Does patient have a Living Will or Medical Power of Attorney?

YES (if yes, please provide a copy) **NO**

I acknowledge that all of the information given is true and correct and that it has been furnished to this office with full knowledge that, regardless of responsible party listed above, the person signing this document is ultimately liable for all said services rendered and that he/she is contractually bound to pay for said services.

Further, by signing below, I give Hall Medical, LLC permission to bill my insurance(s) on my behalf.

Patient or Guardian Signature

X_____ Date_____