Hall Medical

Patient Information

First Name_____ **Last Name**_____

Date of Birth___/____/_____ **Social Security** _____-____-_____

Street Address_____

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

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

Preferred Number _____ **Sex:** Male Female

Email:_____

Marital Status: Single Married Divorced Widowed Partner

Race: ___Asian ___Black or African American ___White ___Other

Ethnicity: ___Not Hispanic ___Hispanic, Latino/a ___Other

Emergency Contact

Name_____

Relationship to Patient_____

Address_____

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

[ ] This person is authorized to receive health information on my behalf

Person Responsible for Bills (if different than patient)

Name_____

Relationship to Patient_____

Address_____

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

Pharmacy

Name _____ **Address or Crossroads** _____

I acknowledge that all of the information given is true and correct.

By signing below, I give Hall Medical, LLC permission to bill my insurance(s) on my behalf and am responsible for paying for all rendered services, including the amount not covered by insurance.

Patient Signature

X_____ Date_____

Return forms via email to office@hallmedicine.com. Sending via USPS, fax, or in person is also acceptable.