Jonathan D. Hall, M.D., F.A.C.S.
PATIENT INFORMATION

Name:_____ Age:_____ D.O.B.:____/____/____
Mailing Address:_____ City_____
State:_____ Zip Code:_____ Social Security No.:_____
Female: ☐ Male: ☐ Occupation:_____
Home Phone: ( )_____ Daytime Phone: ( )_____
Mobile Phone: ( )_____ E-mail:_____
In case of emergency, please notify:_____ Phone: ( )_____
Relationship to Patient:_____

PERSON RESPONSIBLE FOR PAYMENT

Self: ☐ Parent, if patient is under 18: ☐
Marital Status: Single☐ Married☐ Divorced☐ Widowed☐
Name (if different from above):_____
Mailing Address (if different from above):_____
City:_____ State:_____ Zip Code:_____
Employer Name:_____
Employer Address:_____ City:_____
State:_____ Zip Code:_____ Work Phone: ( )_____
Spouse Employer:_____ Work Phone: ( )_____

INSURANCE INFORMATION

Primary Insurance:_____ Subscriber:_____
I.D. #:_____ Group #:_____ Rel. to Subscriber:_____
Secondary Insurance:_____ Subscriber:_____
I.D.#:_____ Group #:_____ Rel. to Subscriber:_____

WORKER'S COMPENSATION INFORMATION (if applicable)

Name of Insurance Carrier:_____
Billing Address:_____ City:_____
State:_____ Zip Code:_____ Phone: ( )_____
Contact Person:_____ Claim #:_____

INSURANCE AUTHORIZATION & ASSIGNMENT:
I hereby authorize Jonathan D. Hall, M.D. to furnish information to insurance carriers concerning my illness and treatments and I herby assign to the physician all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.
Date:_____ Signature:_____

MEDICARE PATIENTS:
I request that payment under the medical insurance program be made directly to Jonathan D. Hall, M.D. I further authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, or carriers of insurance companies, and information needed for this authorization to be used in place of the original.
Date:_____ Signature:_____

MANAGED HEALTH CARE MEMBERS:
As a member of a Managed Care Health Plan, I understand that I have an obligation to obtain a referral for specialist services from my Primary Care Physician **prior** to making an appointment. I acknowledge that if I do not have a referral for services rendered **at the time of my visit**, I am responsible for payment of said services should they be denied by my Managed Care Health Plan.
Date:_____ Signature:_____