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: _____Email: _____

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): _____

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: _____

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

Contact Person: _____ Claim #: _____

INSURANCE AUTHORIZATION & ASSIGNMENT:

I hereby authorize Jonathan D. Hall, M.D. to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for my 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: _____