Bonnie Huang Hall, MD PHD

New Patient Contact Information

Name: _____

DOB: _____

Address: (in case I need to mail you information about your health)
_____

Email address (for sending you receipts/paperwork)
_____

Phone: (for calling you about your health) _____

Please initial
I allow Dr. Hall to leave personal medical information on my phone: [ ] Yes____ [ ] No ___
I allow Dr. Hall to mail me medical information: [ ] Yes____ [ ] No____
Who can I discuss personal medical information with?
[ ] Myself only _____
[ ] Myself and other people listed below: ____
(Name, relationship, and Phone number)
_____
_____

Signature _____ Date _____

NAME DOB Date:
New Patient History

Past Medical History: [ ] none [ ] Diabetes [ ] Blood Pressure [ ] Cholesterol

Other: _____

Past Surgical History: [ ] None [ ] Appendix removed [ ] Gallbladder removed

Other: _____

Medications:

Family Medical Problems:

Allergies: [ ] None _____

Alcohol
Smoking
Drugs