

130 West Route 66,
Suite 110
Glendora, California, 91740



626.914.3384
FAX 626.914.6254
www.hillmedical.com

PLEASE PRINT

Account Number:

PATIENT

LAST NAME			FIRST			MI	HOME PHONE		
STREET					CITY			STATE	ZIP CODE
BIRTHDATE	AGE	SEX	SOC.SEC.NO.			REFERRING DOCTOR			PATIENT STATUS <input type="checkbox"/> NEW <input type="checkbox"/> RETURNING
EMPLOYER					OCCUPATION			DATE OF HIRE	
EMPLOYER ADDRESS			CITY			STATE	ZIP CODE	WORK PHONE	
REASON FOR VISIT <input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY		INJURY/ACCIDENT CAUSED BY <input type="checkbox"/> PERSONAL <input type="checkbox"/> AUTO <input type="checkbox"/> WORK			* Patient E Mail* (see below)				

RESPONSIBLE PARTY

LAST NAME		FIRST		MI	STREET				
CITY			STATE	ZIP CODE	HOME PHONE		BIRTHDATE	RELATIONSHIP TO PATIENT	
EMPLOYER					OCCUPATION			LENGTH OF EMPLOYMENT	
EMPLOYER ADDRESS						WORK PHONE		SOC. SEC. NO.	

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I consent to and authorize the administration of all diagnostic and therapeutic treatments by The Hill Medical Corporation ("Hill") radiologists that may be considered advisable or necessary in the judgement of the attending radiologist. I have been offered a copy of The Hill Medical Corporation's Notice of Privacy Practices. I authorize Hill to furnish my insurance carrier(s) information regarding my history, physical findings and treatment rendered.

SIGNATURE			DATE			WITNESS		
X								

AUTHORIZATION TO PAY BENEFITS AND ACCEPTANCE OF PAYMENT RESPONSIBILITY

I authorize payment of benefits directly to the provider for the services rendered. In addition, in the event that my insurance carrier(s) refuse payment for services rendered, I agree that I will be held financially responsible for payment.

SIGNATURE			DATE			WITNESS		
X								

EMERGENCY CONTACT

NAME		RELATIONSHIP TO PATIENT	HOME PHONE	WORK PHONE

PRIOR FILM AND REPORT RELEASE

To Whom it May Concern:
I Authorize the release of my _____ films and reports in addition to any Surgical Pathology reports pertaining to my past medical history to:

Hill Imaging Center, Inc.
130 West Route 66, Suite 110
Glendora, CA 91740

Attention: File Room

Thank you for your cooperation,

X _____ Date: _____

This form is only used to obtain information from outside facilities for our Doctor's use.

This release expires 1 year from the date it is signed.

*** E Mail Address for patient satisfaction survey use only and will not be shared.**