



Account Number:

**PATIENT**

LAST NAME		FIRST		MI	HOME PHONE	
STREET			CITY		STATE	ZIP CODE
BIRTHDATE	AGE	SEX	SOC.SEC.NO.		REFERRING DOCTOR	
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
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.**