PLEASE WRITE IN BLACK INK www.hilltopmedicalclinic.com ** www.facebook.com/hilltopmedicalclinic.com

PATIENT

LAST NAME _____ FIRST _____ MI _____ SEX _____

MAILING ADDRESS

STREET _____ APT# _____

CITY _____ STATE _____ ZIP _____

PATIENT'S BIRTHDATE _____ AGE ____ EMPLOYER _____

HOME PH# _____ CELL PH# _____ EMPLOYER'S PH# _____

EMAIL ADDRESS: _____ SPOUSE'S NAME _____

IF PATIENT IS A MINOR, PLEASE FILL OUT THIS SECTION:

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

PARENTS NAMES _____ PARENTS SOCIAL SECURITY # _____

RESPONSIBLE PARTY'S PHONE # _____ CELL PHONE # _____

RESPONSIBLE PARTY'S EMPLOYER _____ EMPLOYER'S PHONE # _____

Emergency Contact:

NAME _____ PHONE # _____

Please list the person(s) that we, as healthcare professionals - using our best judgment - may contact and/or disclose your health or payment information.

****MEDICAL RECORDS RELEASE** AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Hilltop Medical / Hilltop Medical West must have authorization from the patient (by law) to speak to anyone else regarding health and/or medical billing. This includes spouses and/or parents of children that are 18 years or older. I understand that authorizing the disclosure of health/billing information in voluntary. I can choose not to designate anyone to release my records to. I understand I have the right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Please mark ONE of the following boxes.

[ ] I DO NOT WISH to designate an authorized person at this time.

[ ] I authorize Hilltop Medical / Hilltop Medical West to release any health and/or billing information to the following individual (other than parent of a minor):

Name: _____ Relationship: _____

OUR POLICY IS PAYMENT AT THE TIME OF SERVICE - WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, OR CHECK

PRIMARY INSURED _____

SOCIAL SECURITY # OF PRIMARY INSURED _____

TREATMENT AUTHORIZATION – I grant permission to the physician and staff as directed by the physician of Hilltop Medical Clinic/Hilltop Medical Clinic West to perform any medical or surgical treatment and to administer such local anesthetics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient for today and future office visits. For a child patient – I understand by authorizing treatment I am also accepting responsibility to be the financial party on this and all future office visits for this minor patient until (s)he is legally considered and adult at age 18.

_____ _____ _____

SIGNATURE OF PATIENT/AUTHORIZED LEGAL GUARDIAN OR PARENT SIGNER'S SOCIAL SECURITY# DATE

HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ Phone book ☐ Internet ☐ Television ☐ Other: _____