HILLTOP IMAGING & DIAGNOSTIC CENTER
2970 Hilltop Mall Rd #103, Richmond, CA 94806
(510) 223-5122 | Fax: (510) 223-5125 | HilltopMRI.com

PATIENT CONSENT FORM – PLEASE PRINT CLEARLY

ARE YOU A PREVIOUS PATIENT? YES ☐ NO ☐ (Check the box)	**DATE:**
ARE YOU PREGNANT? YES ☐ NO ☐ (Check the box)	**SEX:** Male ☐ Female ☐ (Check the box)
DOB:	**SSN:**
First Name:	**Middle Initial:**
Last Name:	
Address (INCLUDE APT #):	
City:	**Zip Code:**
Phone Number:	
Cell Phone Number:	

PERSONAL INJURY, AUTO ACCIDENTS & WORKERS COMPENSATION PATIENTS

Select one (check the box):	PERSONAL INJURY ☐ AUTO ACCIDENT ☐ WORKERS COMPENSATION ☐
Employer Name (IF WORKERS COMP):	
Attorney Name:	
Attorney Phone:	
Date of Injury:	
LIST ANY ADDITIONAL INFORMATION :	

PRIVATE INSURANCE PATIENTS: Must be filled out if you are not the Primary Holder for your insurance or the patient is a MINOR!

Primary insurance holder name:	
Policy holder SSN:	
Policy holder relationship to patient: (check the box)	Parent ☐ Sibling ☐ Partner ☐ Child ☐ Spouse ☐

I attest the above information provided by me is correct to the best of my knowledge. I have read and understood the entire content of this form and I have had the opportunity to ask about any unclear issues in this regard.

Signature: Date: