MICHAEL C. HILTON, M.D., PSYCHIATRIST

3975 Roswell Road Atlanta, GA 30342 (T) 404-352-4001 (F) 404-352-4009

PATIENT INFORMATION:

FIRST NAME | MIDDLE INITIAL | LAST NAME

SOCIAL SECURITY NUMBER | CIRCLE SEX | BIRTH DATE | AGE

____ ____ ____ - ____ ____ - ____ ____ ____ ____ | Male Female | Month: _______ Day: _______ Year: _____________ | ________

CIRCLE MARITAL STATUS: Never Married Married (# of Marriages: _______) Divorced Separated Widowed

EDUCATIONAL HISTORY: (*Circle* highest school completed and *enter* total number of years of education completed.)

Elementary School Middle School High School College Graduate School Total Years of Education: ________

MAILING ADDRESS (INCLUDE PO BOX AND APARTMENT NUMBER , IF APPLICABLE) | HOME PHONE ( )

CITY | STATE | ZIP CODE | BUSINESS PHONE ( ) | CELL PHONE ( )

PLEASE LIST REASON(S) FOR YOUR EVALUATION TODAY: (work injury, disability, return to work status, custody, guardianship, other legal matter, etc.)

NOTE: WORKERS' COMPENSATION PATIENTS AND INDEPENDENT MEDICAL EXAMINATION PATIENTS NEED NOT FILL OUT THE INFORMATION IN THE SECTIONS BELOW

GUARANTOR IF NOT PATIENT ABOVE:

GUARANTOR'S NAME | RELATIONSHIP TO PATIENT

HOME PHONE ( ) | BUSINESS PHONE ( ) | CELL PHONE ( )

GUARANTOR'S ADDRESS | CITY | STATE | ZIP CODE

PATIENT/GUARANTOR - FINANCIAL RESPONSIBILITY (NOT APPLICABLE TO WORKERS' COMPENSATION PATIENTS)

I understand that *regardless of insurance coverage*, I am *financially responsible for all charges* generated by this patient. Office policy requires *payment at the time of service*. If I have insurance coverage, I will pay for services in full at the time of service and seek reimbursement on my own through my insurance company. Should the insurance company make payment directly to Dr. Hilton when seeking reimbursement, that *payment will be used as credit* against any future fees incurred in this office. *No refund checks will be issued* unless arrangements are expressly approved through Dr. Hilton. My signature below confirms agreement with the above statements.

Print Name:____

Signature:____Date:______________

REFERRAL SOURCE

We would greatly appreciate your taking a moment to indicate by check mark how you heard about Dr. Michael C. Hilton.

____ Physician ____ Friend ____ White Pages (Telephone Book) ____ Internet

____ Yellow Pages ____ Family ____ Insurance Co. Provider List ____ Other

Please give detailed information for the source you checked above:

Name: ____ Phone: ( ) ____________________

Address: ____ Cell: ( ) ____________________

____ Fax: ( ) ____________________