

OPHTHALMIC ASSOCIATES OF BILLINGS, L.L.C.
1232 NORTH 30TH STREET
BILLINGS, MT 59101
PLEASE FILL FORM OUT COMPLETELY

ID # _____ MALE FEMALE

PATIENT NAME _____ Mr. Mrs. Ms. Miss Dr. _____

LAST FIRST MIDDLE
SOCIAL SECURITY NUMBER _____ AGE _____

DATE OF BIRTH _____ HOME PHONE _____ CELL _____

MAILING ADDRESS _____ OTHER PHONE _____

STREET ADDRESS _____

SUMMER ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ BUSINESS PHONE _____

EMPLOYED BY _____ ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

HOW MAY WE CONTACT YOU? (Please check all that apply) HOME WORK CELL OTHER

MAY WE LEAVE A MESSAGE? (Please check all that apply) HOME WORK CELL OTHER

PERSON RESPONSIBLE FOR PAYMENT _____ SELF SPOUSE
 PARENT OTHER

DATE OF BIRTH _____ S.S.# _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ EMPLOYED BY _____

ADDRESS _____ BUSINESS PHONE _____

PRIMARY INSURANCE _____ POLICY # _____

SECONDARY INSURANCE _____ POLICY# _____

IF NO INSURANCE, PLEASE CHECK YOUR METHOD OF PAYMENT CASH CHECK CREDIT CARD

I HAVE READ THE CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FORM. I HAVE ALSO BEEN GIVEN ACCESS TO THIS CLINIC'S PRIVACY POLICY; I UNDERSTAND BOTH DOCUMENTS AND AGREE TO THE OUTLINED CONDITIONS BY SIGNING BELOW. I FURTHER AUTHORIZE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES.

DATED _____ PATIENT SIGNATURE _____

IF YOU ARE SIGNING AS PERSONAL REPRESENTATIVE OF THE PATIENT, DESCRIBE YOUR RELATIONSHIP TO THE PATIENT AND THE SOURCE OF YOUR AUTHORITY TO SIGN THIS FORM.

RELATIONSHIP _____ PRINT NAME _____

SOURCE OF AUTHORITY _____