OPHTHALMIC ASSOCIATES OF BILLINGS, L.L.C.
4033 AVENUE B
BILLINGS, MT 59106
Please fill out form 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_____ Social Security Number: _____

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 and the Conditions of Treatment forms. I have also been given access to this Clinic's Privacy Policy; I understand these documents and agree to the outlined conditions by signing below. I further authorize benefits be paid directly to the Physician/Clinic/Facility, 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_____