OPHTHALMIC ASSOCIATES OF BILLINGS, L.L.C.
4033 AVENUE B
BILLINGS, MT 59106
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____