the eye clinic
surgicenter | 2475 Village Lane. Billings, MT. 59102 T: (406) 252.6608 F: (406)252.6600

Patient's Name _____ Maiden Name: _____
(last) (first) (middle initial)

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Cell (_____) _____

Date of Birth _____ Age _____ Sex: [ ] F [ ] M Marital Status: [ ]S [ ]M [ ] W [ ] D

S.S.# _____ E-mail Address _____

Employment status: [ ] Full Time [ ] Part Time [ ] Retired or [ ] Student

Employer Name: _____ Phone:(_____) _____

Address _____ City _____ State _____ Zip _____

[ ] Spouse [ ]Parent [ ] Guardian [ ] POA **(bring documentation)** Name _____

S.S.# _____ E-mail Address _____

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Cell (_____) _____

[ ] Parent #2 [ ] Guardian #2 [ ] POA #2 **(bring documentation)** Name _____

S.S.# _____ E-mail Address _____

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Cell (_____) _____

Whom May We Contact in Event of Emergency?

Name _____ Relationship _____

Phone (_____) _____

Address _____

How did you hear about us? [ ] Friend _____ [ ] Doctor [ ] Insurance [ ] Paper
[ ] Radio [ ] Facebook [ ] Internet [ ] Yellowpages [ ] Billboard

Name of doctor who did your last eye exam: _____ When _____

Referred here by Dr _____

Primary Care Physician: _____ Phone # _____

Assignment and release Authorization: This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all clinical treatments which in the judgment of my physician, may be considered necessary for care. I authorize The Eye Clinic Surgicenter to settle my insurance claim with the provided insurance company on by behalf. Authorization by all payors to pay all physician benefits directly to The Eye Clinic Surgicenter is hereby granted. I understand that regardless of insurance coverage, I am financially responsible to The Eye Clinic Surgicenter for all charges. I will be assessed a monthly finance fee of 1.5% for any unpaid patient balances. If my account is turned to a third party for collections my account will be assessed a 35% Collection fee.

Important note: Refractions are seldom covered by insurance companies. Any patient balance will be collected at the time of service.

_____ _____

Signature of Patient or Personal Representative Date

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