EYE CLINIC OF GREAT FALLS
509 2ND AVENUE NORTH
GREAT FALLS, MT 59401

PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME _____

PATIENT BIRTH DATE _____ ❑MALE ❑FEMALE SSN _____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

E-MAIL (optional) _____

PATIENT'S EMPLOYER _____

SPOUSE'S NAME _____

EMERGENCY CONTACT / PHONE # _____

COMPLETE THIS SECTION IF THE PATIENT IS UNDER 18 YEARS OF AGE

MOTHER'S NAME _____ FATHER'S NAME _____

MOTHER'S SSN _____ FATHER'S SSN _____

MOTHER'S DOB _____ FATHER'S DOB _____

MOTHER'S PHONE _____ FATHER'S PHONE _____

MOTHER'S EMPLOYER _____ FATHER'S EMPLOYER _____

INSURANCE - PLEASE PRESENT YOUR CARD(S) AT EACH VISIT

MEDICAL INS. CARRIER _____ PRIMARY MEMBER _____

VISION INS. CARRIER _____ PRIMARY MEMBER _____

WORKERS COMP INJURY? ❑ YES ❑ NO DATE OF INJURY _____ CLAIM # _____

AUTO ACCIDENT? ❑ YES ❑ NO DATE OF LOSS _____ CLAIM # _____

IMPORTANT INFORMATION - PLEASE READ

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.
I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
I understand that I am financially responsible for all charges whether or not paid by my insurance.
I understand that should I default on payment of my account, I am responsible for all costs of collections, up to and including 45% of the balance fee as may be charged by a collection agency, including attorney and/or court costs which will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

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