Great Falls Obstetrical & Gynecological Associates
1400 29th St. S., Suite 101
Great Falls, Mt 59405
Office Phone: 406-761-7924 Office Fax:406-791-7945

Pharmacy:_____

Last Name | Legal First Name | M.I.

Mailing Address | City | State | Zip Code | Cell Phone

Social Security Number | Date of Birth | Gender | Marital Status | Home Phone

Employer | Work Phone | Previous Last Name(s)

All professional services are charged to the patient. Insurance forms will be completed to help expedite insurance carrier payments, provided an insurance card is presented. However, the patient is responsible for all fees, regardless of insurance coverage. Payment is also due as services are rendered unless other arrangements have been made in advance.

Primary Insurance | First & Last Name of Policy Holder

Secondary Insurance | First & Last Name of Policy Holder

Medicare #_____ *(Is Medicare PRIMARY or SECONDARY)* Medicaid #_____

Third Insurance | First & Last Name of Policy Holder

Name of Insurance Policy Holder | Date of Birth | Relationship to Patient | Social Security Number

Mailing Address | City | State | Zip Code | Primary Phone

Employer | Work Phone

Your health information is kept confidential. If a claim is submitted, this information will be shared with your insurance company and kept confidential by your insurance company. You have a right to request that we restrict how your information is used, but we may not agree to the requested restrictions. By signing below, you authorize the release of any medical information to you insurance company when necessary to process your claim. Also, by signing below, you give consent for medical examination (including drug testing) , treatment, and collection of payment. If your account should be turned to our collection agency, you will be responsible for all costs of collections including attorney's fees and court costs.

X_____ X_____

Patient Signature (Guardian, if a Minor) Date