MOVSHOVICH PC
DIABETIC EYE CENTER OF NEW JERSEY

596 Anderson Ave Ste 101, Cliffside Park, NJ 07010
Tel: 201-943-0022 Fax:201-313-7146 e-mail: eyeprofessionals@verizon.net

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____________________ ____________________ __________ __________ __________
Last Name **First Name** **D.O.B** **Female** **Male**

____________________ __________ __________ __________
Address **City** **State** **Zip**

Home Phone: __________ **Cell Phone:** __________ Email Address:__________

Primary Language (Check one) ________ **English** _______ **Spanish** ______ **Other (indicate)**______________________________

Race (check one) _____American Indian/Alaskan______ Asian ______ Black/African American _______ Native Hawaiian ______ White____ Other

Decline to Answer: ________

Ethnicity: (Please check one) ______ Not Hispanic or Latino, ______ ispanic or Latino ______ Unknown _______Decline to Answer

Social Security #_________________________ **Employer**____

Employer Address: ___________________________ **City**_________________________ **State**_________ **Zip:**____________

Occupation: ______________________________________ **Employed Since**______________________________

Emergency Contact: ______________________________________ **Phone#**______________________________________

Reason for my visit: ____

INSURANCE INFORMATION

Primary Insurance Co __________________________ **Policy Holder**______________________________ **D.O.B.**___________

Primary Holder's SS # Or ID #________________ **Group #**_____________________ **Employer**______________________________

Secondary Insurance Policy Holder Name: ____**D.O.B** _____________

Secondary Holder's SS # Or ID # ___________________ **Group No.**________________**Employer** _____________________________

REFERRAL INFORMATION

Name of Referring Party:____ **Phone:**___________________________

Name of Primary Care Physician:____ **Phone :** __________________________

Pharmacy Name: __________________________________ **Phone :**________________________

FINANCIALLY RESPONSIBLE PARTY – Must be completed if patient is under 18 years of age or a student.

Name: ______________________________ **Relationship:** _________________________ **DOB:** _____________

Address: _________________________________ **City:** ___________________ **State** _______________ Zip ________

Home Phone: ___________________ **Cell Phone:** ___________________ **Social Security #** _______________________

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to the doctor of any medical benefits otherwise payable to me. I understand I am financially responsible to him/her for charges not covered by this assignment. I authorize him/her to release any information requested to support my claim including any information which constitutes a psychiatric communication and/or relates to treatment of alcohol and drug abuse.

FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default.

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT: I understand that if at any time my insurance plan does not cover my services I agree to pay all charges.

Signature____________________________________ **Date:**______________________________