# MOVSHOVICH PC FAMILY EYE CENTER

**596 Anderson Avenue, Suite 101**
**Cliffside Park, NJ 07010**

**Tel: 201-943-0022** **www.andersoneyecenter.biz** **Fax: 201-313-7146**

## Patient Information

Last Name: _____ First Name: _____

Address: _____ Apt./Suite No. _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____Work:(____) _____

Cell Phone: (____) _____ Marital Status: _____

Sex: M____ F_____ Birth Date: ____/ ____/ _____ SS # _____-_____-_____

## Primary Care Physician

Name: _____

Address: _____

Phone: (____) _____ Fax: (_____) _____

## Insurance Information

Primary Insurance Plan _____Co-pay amount: $_____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber's Employer: _____Address_____

SS #: _____-____-_____ Date of Birth: _____/____/_____

Policy No.: _____ Group No: _____

### Agreement

1. I authorize the release of any medical information necessary to process my insurance claims(s).
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original
5. I agree to pay all charges not covered by my insurance carrier(s). These charges include but not limited to deductibles and co-payments on my insurance policy.

_____ _____

**Patient (Representative) Signature** **Date**

Rev. 10/13