MOVSHOVICH PC FAMILY EYE CARE CENTER

596 Anderson Ave Ste 101
Cliffside Park NJ 07010

andersoneyecenter.biz

Tel: 201-943-0022
Fax: 201-313-7146

Patient Information

Last Name: _____ First Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: (___) _____ Work:(____) _____ Cell Phone: ( )_____

Marital Status: ___Divorced __ Marrried __Single____ Widowed_____ Sex: M____ F_____

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

Physician Information

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:_____

1. I authorize and reques t payment of medical benefits directly to my physicians.
2. I authorize the release of any medical information necessary to process my insurance claims(s).
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.

Signature Date