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

Name_____**D.O.B**._____ Male ☐ Female ☐
Last First Middle Initial

Address_____ **City**_____ **State**_____ **Zip**_____

Phone ( )_____ **Cell Phone** ( )_____

Email _____

Primary Language (please circle one) English, Spanish, Other (indicate)_____
Race (please circle one): American Indian/Alaskan, Asian, Black/African American, Native Hawaiian, White, Other, or Decline to Answer.
Ethnicity: (please circle one): Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline to Answer.

Social Security #_____ **Employer**_____

Employer Address_____ **City**_____ **State**_____ **Zip**_____

Occupation_____ **Employed Since**_____

Emergency Contact _____ _____
Name 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 Co._____ **Policy Holder**_____ **D.O.B**._____

Secondary Holder's SS # Or ID #_____ **Group #**_____ **Employer**_____

REFERRAL INFORMATION

Name of Referring Party_____ **Phone ( )**_____

Name of Primary Care Physician_____ **Phone ( )**_____

Pharmacy _____ **Phone ( )**_____

FINANCIALLY RESPONSIBLE PARTY – *Must be completed if patient is under18 or a student.*

Name_____ **Relationship**_____ **D.O.B**_____

Address_____ **City** _____ **State**_____ **Zip**_____

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:_____