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 : movshovichpc@gmail.com
Website : www.movshovichpc.com

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:_________________________________