Ophthalmologists - Optometrists - Opticians •
LASIK, Crystalens, Verisyse, CLs •
Low Vision Service •
Pediatric Eye Care •
Glaucoma Laser, Medical & Surgical •
No-Stitch No-Needles Cataract •
Ophthalmic Plastic & Reconstructive Surgery •

Omar F. Almallah, MD
Christopher D'Alterio, O.D.
Catherine Felicia, O.D.
Erik Mohaber, O.D.

Kenneth B. Ehrlich, O.D.
Bernard Susskind, M.D.
Thomas C. Pidduck, M.D.
Frank DeRienzo, O.D.

Toms River - 732-349-5622
Brick - 732-477-6981
Whiting - 732-849-4444

Marlboro - 732-972-1015
Barnegat - 609-698-2020

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Patient Information Sheet

LAST NAME	FIRST NAME		MI
ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY #	HOME PHONE # ( )	BUSINESS PHONE # ( )	BIRTHDATE / /	AGE

SEX	MARITAL STATUS S M D W	NAME OF REFERRING DOCTOR OR PATIENT

RESPONSIBLE PARTY FOR BILLING: (CIRCLE ONE)
1-SELF 2-SPOUSE 3-PARENT 12-W/COMP

NAME OF RESPONSIBLE PARTY	ADDRESS, IF DIFFERENT FROM ABOVE

INSURANCE COMPANY GROUP #	POLICY #	SUBSCRIBER	RELATIONSHIP
1.			
2.			

PATIENTS OCCUPATION:
BUSINESS ADDRESS: EMPLOYER:

SPOUSE'S NAME: OCCUPATION:

NAME OF FAMILYDOCTOR/INTERNIST
MILITARY SERVICE (ACTIVE) YES / NO DESCRIPTION:

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. SHOULD MY ACCOUNT BECOME DELINQUENT, I AGREE TO PAY INTEREST ON THE OUTSTANDING BALANCE OWED AT THE MAXIMUM AMOUNT PERMITTED BY LAW.
IF CENTER UNDETAKES COLLECTION EFFORTS TO RECOVER ANY PAST DUE AMOUNTS, I AGREE TO PAY ALL REASONABLE COSTS INCURRED, INCLUDING ATTORNEY'S FEES.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY,ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

I AUTHORIZE THE DOCTOR TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DOCTORS ALMALLAH, FELICIA, SUSSKIND, D'ALTERIO, EHRLICH, MOHABER, DERIENZO OR PIDDUCK FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE________________________________ DATE________________