



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 •

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 Christopher D'Alterio, O.D.
 Catherine Felicia, O.D.
 Erik Mohaber, O.D.

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

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

oceancountyeye.com

Patient Information Sheet

LAST NAME		FIRST NAME		MI	
ADDRESS		CITY		STATE	
SOCIAL SECURITY #		HOME PHONE #		BUSINESS PHONE #	
				BIRTHDATE / /	
AGE		NAME OF REFERRING DOCTOR OR PATIENT			
SEX		MARITAL STATUS S M D W			
RESPONSIBLE PARTY FOR BILLING: (CHECK ONE)					
		1-SELF		2-SPOUSE	
				3-PARENT	
				12-W/COMP	
NAME OF RESPONSIBLE PARTY		ADDRESS, IF DIFFERENT FROM ABOVE			
INSURANCE COMPANY		GROUP #		POLICY #	
1.				SUBSCRIBER	
				RELATIONSHIP	
2.					
PATIENTS OCCUPATION:					
BUSINESS ADDRESS:			EMPLOYER:		
SPOUSE'S NAME:			OCCUPATION:		
NAME OF FAMILY DOCTOR/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 UNDERTAKES 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 _____