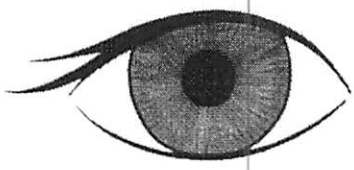

# Dr. Alan Ross
## Optometrist

Thank you for selecting our office.
We look forward to working with you in maintaining your vision.

Today's Date: _____ Birth Date: _____

Patient:Dr./Mr./Mrs./Ms/Miss _____
CIRCLE ONE Last First M.I.

Suffix: Jr./I/II/III/IV/ Gender: _____ SS#: _____
CIRCLE ONE

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

CHECK ONE
❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Legally Separated

Mobile: _____ Home: _____ Work: _____

CHECK/CIRCLE ONE
❑ Employed FT/PT ❑ Student FT/PT ❑ Not Employed ❑ Active Military ❑ Retired ❑ Self Employed

Language: ❑ English ❑ Spanish ❑ Japanese ❑ French ❑ Declined to Specify ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Caucasian ❑ Unknown ❑ Decline

Racial Heritage: ❑ Asian ❑ White ❑ Native Hawaiian/Pacific Islander ❑ Decline to Specify
❑ American Indian/Alaska Native ❑ Black or African American ❑ Hispanic

Person Responsible
For Payment: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

**We appreciate you choosing our office! Whom may we thank for referring you to our office?**

Name: _____ Phone Number: _____

**If you have been referred by a medical provider we may be sending medical information**

270 Closter Dock Road • Closter, NJ 07624 tel: 201.768.2433 fax: 201.768.1861

# INSURANCE INFORMATION

## VISION INSURANCE:

**Company:**_____ Policy Holder:_____

ID# _____ Group# _____

Policy Holder's Date of Birth: _____

Billing Address:_____

City: _____ State:_____ Zip:_____

## MEDICAL INSURANCE:

**Primary Insurance:**_____ Policy Holder:_____

ID# _____ Group# _____

Insured's Date of Birth: _____

Billing Address:_____

City: _____ State:_____ Zip:_____

**Secondary Insurance:**_____ Policy Holder:_____

ID# _____ Group# _____

Policy Holder's Date of Birth: _____

SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND ANY OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO DR. ALAN ROSS O.D. FOR MY SERVICE FURNISHED BY MY PHYSICAN.I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR PAYABLE SERVICE.

Signature: _____ Date: _____

PAYMENT POLICY

ALL CO-PAYS AND PAYMENTs ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS. IF YOU HAVE INSURANCE, WE WILL BE HAPPY TO BILL THE ESTIMATED PORTION YOUR INSURANCE PLAN COVERS; THE REMAINING BALANCE IS DUE AT TIME OF SERVICE.YOUR CARRIER IS YOUR BEST SOURCE OF INFORMATION REGARDING BENEFITS AND ELIGIBILITY. IF THE INSURANCE DOES NOT PAY, PATIENT IS RESPONSIBLE FOR THE OUTSTANDING PAYMENTS.

Signature: _____ Date: _____

270 Closter Dock Road • Closter, NJ 07624 tel: 201.768.2433 fax: 201.768.1861