EYE SURGERY &
LASER CENTER
Anthony Novak, M.D.
Board Certified Specialty Eyecare

Car Accident Form

Please provide the following information so that we may update your account and bill the proper insurance.

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____

Car Insurance Co Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Contact Person: _____

Date of Accident: _____

Claim #: _____

If you do not have all of this information with you the day of your appointment, you will be responsible for any charges from the service we provide until the information is received.