Dr. Darryl R. Voight ***(973)616-9999***

Welcome

Patient Information:

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Name: _____ Date of Birth: _____SS#_____
First MI Last
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed/Widower ☐ Male ☐ Female

Address_____
and Street City State Zip
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Where do you prefer to receive calls at?_____
Email: _____
Occupation: _____ Employer: _____
Name of Spouse: _____ Work Phone: _____ Cell Phone: _____
Person to call in case of emergency: _____ Phone: _____ Relationship: _____
How did you hear about us? _____ Relationship: _____

Responsible Party:
Name: _____ Date of Birth: _____ SS# _____
First MI Last
Address (if different from Patient): _____
Relationship to patient_____ Phone_____

Insurance Information: (If different from above)
Name of Insured: _____Date of Birth: _____ SS# _____
Occupation: _____ Employer: _____
Relationship to patient: _____ Phone: _____
Insurance Company: _____ Group #: _____ Subscriber #: _____

Additional Insurance: (If any)
Name of Insured: _____Date of Birth: _____ SS# _____
Relationship to patient: _____ Phone: _____
Insurance Company: _____ Group #: _____ Subscriber #: _____

- Please give the assistant your Health Insurance ID Card so that we may make a copy for the record. Although we may not be participating providers in your plan, we will assist you in obtaining reimbursement when applicable.
- Payment is expected when services are rendered and when eyeglasses and/or contact lenses are ordered. I understand that I am responsible for all services and/or materials ordered.
- In order to submit an insurance claim, we must have your authorization to release medical information to your insurance carrier(s). You are responsible for any coinsurance and/or deductibles, as well as any non-covered services.

I authorize the release of any medical and other information necessary to process my insurance claims. I also authorize payment of medical benefits to Dr. Darryl R. Voight, O.D. This authorization applies to all occasions until it is revoked.

_____
Patient/Guardian Signature Date

I have read and/or received Dr. Darryl R. Voight's Notice of Privacy Practices dated April 9, 2003.

Signature: _____ Date: _____Relationship to Patient: _____