Dr. Darryl R. Voight, OD, PC ***(973)696-2020*** ***1680 State Route 23, Ste 170***
Optometric Physician ***Fax (973)616-2737*** ***Wayne, NJ 07470***

Welcome

Patient Name: ______________________________________ Date of Birth: __________SS#________________
First MI Last
Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed/Widower
Street Address: __________________________________ City: ______________State: ________Zip: __________
Home Phone: ______________ Cell Phone: ______________ Where do you prefer to receive calls? ___________
Email: ______________________ Primary Care Physician: _______________________ Phone: ___________
Employed: ☐ Yes ☐ No Occupation: __________________ Employer: ______________________________
Emergency Contact: Name: __________________________ Phone: ___________ Relationship: _______________
How did you hear about our office: _______________________ Relationship: ___________________________

VISION Insurance Information:
Insurance Company: ___________________ Member #: ____________ Group #: _____________ CoPay: _______
Address (if different from Patient): ____
Name of Insured: ___________________________________Date of Birth: ______________ SS# _____________

Responsible Party:
Name of Insured: ___________________________________Date of Birth: ______________ SS# _____________
Address (if different from Patient): ____
Relationship to patient ___________________________________ Phone: ______________________________

Medical /Additional Insurance:
Insurance Company: ___________________ Member #: ____________ Group #: _____________ CoPay: _______
Address (if different from Patient): ____
Name of Insured: ___________________________________Date of Birth: ______________ SS# _____________

- Patient may be responsible for comprehensive eye exam procedure if no medical diagnosis is found. In addition, patient may be responsible for the refraction (the procedure to determine your eyeglass prescription), which is often a non-covered procedure by most insurance companies but is required by NJ law as part of a comprehensive eye exam.
- Patient may be responsible for Optomap imaging if no medical diagnosis is found or if it is not covered by insurance.
- Payment is expected when services are rendered and when eyeglasses and/or contact lenses are 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, OD, PC. 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, 2013. A Copy of HIPAA is on our website for you to read or you can see it in our office. Please indicate, below, names of anyone you wish to receive any information.

Patient/Guardian Signature: ________________________Date: ___________

CONTACT LENS WEARERS
A contact lens is a medical device, and all contact lenses must be properly fitted and prescribed by an Eye Care Professional.
Your contact lens prescription is valid for 1 year, and requires an annual eye examination and annual contact lens health evaluation ($49) in order to be refilled. This $49 charge is typically not covered by any insurance plans, but is required to monitor your eye health and condition of your contact lenses.
It is my understanding that improper use and inadequate care of contact lenses prescribed for me can possible lead to eye irritation, infections, corneal injury and permanent vision loss. **Initial** ____

Health History (Adult)

Patient Name: ____ Age: ______________ Date: ___________

Date of last comprehensive eye exam by an eye doctor: ____

Reason for Today's Exam ____

Name of individual completing this form ____________________ Relationship to Patient ______________

Do you or anyone in your immediate family have a history of the following?

Medical History

	Pt	**M**	**F**	**Sib**	**No**		**Pt**	**M**	**F**	**Sib**	**No**
1. Diabetes	☐	☐	☐	☐	☐	4. Cholesterol	☐	☐	☐	☐	☐
2. High Blood Pressure	☐	☐	☐	☐	☐	5. Cancer	☐	☐	☐	☐	☐
3. Thyroid Condition	☐	☐	☐	☐	☐						

Ocular History

	Pt	**M**	**F**	**Sib**	**No**		**Pt**	**M**	**F**	**Sib**	**No**
1. Glaucoma	☐	☐	☐	☐	☐	4. Cataracts	☐	☐	☐	☐	☐
2. Macula Degeneration	☐	☐	☐	☐	☐	5. Turned or Lazy eye	☐	☐	☐	☐	☐
3. Retinal Problems	☐	☐	☐	☐	☐						

Please list all medications you are currently taking ____
____

*Please list any known drug and/or environmental allergies ______________________________________
____

Date of last complete physical exam with blood work: ____

Do you, or have you ever had any of the following conditions involving your eyes?

☐ Eye Surgery ☐ Sensitivity to light ☐ Eye infection or other disease
☐ Eye injury ☐ See Floaters or Spots ☐ See flashes of light
☐ Double Vision ☐ Poor Distance Vision ☐ Eye Strain
☐ Severe Eye Pain ☐ Poor Near Vision ☐ Eyes burn, itch, or water

Do you wear contacts? ☐ Yes ☐ No Have you ever worn contacts? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Did you want new glasses today? ☐ Yes ☐ No
If you do wear glasses, when do you wear them?

☐ All the time ☐ Reading/near work ☐ Computer Work
☐ Work Safety ☐ Distance task only ☐ Other ________________________

Are you interested in information about Laser Vision Correction? ☐ Yes ☐ No

Do you work at a computer? ☐ Yes ☐ No If yes, how many hours per day: ________________________

What hobbies or sports do you participate in? ____