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 my eye health and condition of my contact lenses.
It is my understanding that improper use and inadequate care of contact lenses prescribed for me can possibly lead to eye irritation, infections, corneal injury and permanent vision loss. **Initial ____**

Health History (Child)

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 _____

Does the child or anyone in the child's 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 the child is currently taking _____

*Please list any known drug and/or environmental allergies _____

_____

Date of child's last complete physical exam with blood work: _____

Does the patient have or ever had any of the following conditions involving their eyes?

☐ Eye Surgery ☐ Sensitivity to light ☐ Eye infection or other disease
☐ Eye injury ☐ Poor Distance Vision ☐ Eye Strain
☐ Poor Near Vision ☐ Eyes burn, itch, or water

Does your child wear contacts? ☐ Yes ☐ No Has the child ever worn contacts? ☐ Yes ☐ No

Does the patient currently wear glasses? ☐ Yes ☐ No Does the patient need new glasses today? ☐ Yes ☐ No
If the patient does wear glasses, when does he/she wear them?

☐ All the time ☐ Reading/near work ☐ Computer work/games
☐ Sports ☐ Distance/Blackboard ☐ Other _____

Does he/she use a computer or play video games? ☐ Yes ☐ No If yes, how many hours per day: _____

What hobbies or sports does her/she participate in? _____