Dr. Darryl R. Voight, OD, PC Optometric Physician

(973)696-2020 Fax (973)616-2737 **Welcome**

1680 State Route 23, Ste 170 Wayne, NJ 07470

| First Male Female Marital Status: Single Married Divorced Widowed/Widower Street Address: City: State: Zip: | Patient Name: | | Date of Birth: _ | SS# | |
|---|--|---|---|--|--|
| 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: Employer: Emergency Contact: Name: Phone: Relationship: How did you hear about our office: Phone: Relationship: WISION Insurance Information: Relationship: Member #: Group #: CoPay: Address (if different from Patient): Name of Insured: Date of Birth: S\$# Responsible Party: Name of Insured: Date of Birth: S\$# Address (if different from Patient): Phone: Member #: Group #: CoPay: Address (if different from Patient): Phone: Medical /Additional Insurance Ompany: Member #: Group #: CoPay: Address (if different from Patient): Phone: Medical /Additional Insurance: Insurance Company: Member #: Group #: CoPay: Address (if different from Patient): Phone: Medical /Additional Insurance: Insurance Company: Member #: Group #: CoPay: Address (if different from Patient): Date of Birth: S\$# • 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 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 service 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 a | First Candam | MI Last | | | 1/XV: 1 |
| Home Phone: | | | | | |
| Email: | Home Phone: Co | ell Phone: | Where do you pr | efer to receive calls | ? |
| Employed: | | | | | |
| Emergency Contact: Name: Phone: Relationship: How did you hear about our office: Relationship: Relationship: WISION Insurance Information: Insurance Company: Member #: Group #: CoPay: 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): Phone: SS# Address (if different from Patient): Phone: CoPay: C | Employed: Yes No Occupati | on: | Employer: | | |
| How did you hear about our office: | Emergency Contact: Name: | | Phone: | _ Relationship: | |
| Name of Insured: | | | | | |
| Address (if different from Patient): Name of Insured: | | | | | |
| Name of Insured: | | | | : | CoPay: |
| Name of Insured: | Address (if different from Patient): _ | | | | |
| Name of Insured: | Name of Insured: | | Date of Birth: | SS# | |
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| Relationship to patient | Address (if different from Patient): _ | | | | |
| Insurance Company: | Relationship to patient | · · · · · · · · · · · · · · · · · · · | Phone: | | |
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| | Patie | ent/Guardian Signature: | | Dat | e: |

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 (\$69) in order to be refilled. This \$69 charge is typically <u>not</u> 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: | | | | | | | |
| | | | | | | | |
| Name of individual completing this form | | | | | | | |
| Do you or anyone in your | immediate family | y have a histor | y of the following? | | | | |
| Medical History | | | | | | | |
| | Pt M F Sib No | 4. Classass | Pt M F S | | | | |
| | | | | | | | |
| 2. High Blood Pressure3. Thyroid Condition | | 3. Cancer | |] [] | | | |
| 3. Thyroid Condition | | | | | | | |
| Ocular History | Pt M F Sib No | | Pt M | F Sib No | | | |
| 1. Glaucoma | | 4. Cataract | | | | | |
| 2. Macula Degeneration | | | r 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 phy | vsical exam with b | | | | | | |
| Do you, or have you ever | had any of the fo | llowing condit | ions involving your | eves? | | | |
| ☐ Eve Surgery | ☐ Sensitivity | to light | ☐ Eye infection o | r other disease | | | |
| ☐ Eye injury | ☐ See Floater | rs or Spots | ☐ See flashes of l | ight | | | |
| ☐ Double Vision | ☐ Poor Distar | nce Vision | ☐ Eye Strain | | | | |
| ☐ Severe Eye Pai | n □ Poor Near | Vision | ☐ Eyes burn, itch | , or water | | | |
| Do you wear contacts? \square Yes \square No \square Have you ever worn contacts? \square Yes \square No | | | | | | | |
| Do you currently wear glasses? \square Yes \square No If you do wear glasses, when do you wear them? Did you want new glasses today? \square Yes \square No | | | | | | | |
| \Box All the time | ☐ Reading/ne | ar work | ☐ Computer Wor | ·k | | | |
| ☐ Work Safety | ☐ Distance ta | sk only | ☐ Other | | | | |
| Are you interested in info | ormation about Las | ser Vision Cor | rection? Yes 1 | No | | | |
| Do you work at a comput | er? 🗆 Yes 🗆 No | If yes, how r | nany hours per day: | | | | |
| What hobbies or sports do | o vou narticinate i | n? | | | | | |