

Welcome

Patient Name: _____ Date of Birth: _____ SS# _____
 First MI Last
Grade: _____ Gender: Male Female
Parent/Guardian's Name: _____ Date of Birth: _____ SS# _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Where do you prefer to receive calls? _____
Primary Care Physician: _____ Phone: _____
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# _____

- Parent/Guardian 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.
- Parent/Guardian 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 child's 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.

Parent/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.

Parent/Guardian Signature: _____ **Date:** _____

I authorize the release of my child's health information to the following individual(s). Please list their names and relationship to the child below.

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 (\$79) in order to be refilled. This \$79 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Thyroid Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

Ocular History

- | | Pt | M | F | Sib | No | | Pt | M | F | Sib | No |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Turned or Lazy eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Retinal Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

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?

- | | | |
|-------------------------------------------|----------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Eye infection or other disease |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Poor Distance Vision | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Poor Near Vision | <input type="checkbox"/> 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?

- | | | |
|---------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Reading/near work | <input type="checkbox"/> Computer work/games |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Distance/Blackboard | <input type="checkbox"/> 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 participates in? _____