Oakland Vision Center

350 Ramapo Valley Rd, Suite 21
Oakland, NJ 07436

Patient Information:

Name ____________________ Preferred Name ____________

Date of Birth ____________ Gender_ M/F_ Email ____________

Address ____________________

City ____________ State ____________ Zip ____________

Home Phone ____________ Mobile Phone ____________ Preferred ☐Home☐Mobile

Occupation ____________

Vision Insurance Information:

☐VSP ☐Eyemed ☐Davis ☐Spectera ☐Superior ☐Other ____________

Member Name ____________________ Member Date of Birth ____________

Member ID Number ____________ SS# (if needed) ____________

Medical Insurance Information:

Primary Insurance Company ____________________

Member Name ____________________ Member Date of Birth ____________

Member ID Number ____________

Who referred you to our office? ____________________

Please include an **emergency contact**, if desired:

Name ____________________ Relationship ____________

Home/Mobile Phone ____________ Work Phone ____________

All patient information is strictly confidential. Please include a person, other than self, whom we may **contact with confidential medical information**, if desired.

Name ____________________ Relationship ____________

Home/Mobile Phone ____________ Work Phone ____________

I understand I am responsible for any co-payments associated with my examination and insurance benefits at the time of service.

Patient/Guardian Signature ____________________ Date ____________

When was your **last eye exam**? ________________________________

Who is your **Primary Care Physician**? ________________________________

What is the main reason for your visit today?________________________________

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Please check the following **Medical conditions** you currently have, or have had in the past:

☐ Diabetes Type I ☐ Diabetes Type 2 ☐ High Cholesterol ☐ Hypertension ☐ Cancer

☐ Asthma ☐ Heart conditions ☐ Headaches ☐ Migraines ☐ TBI

☐ Autoimmune diseases: ____________________ ☐ Other ________________________

Are you currently **Pregnant** or **Nursing**? Y / N

Please check the following **Ocular conditions/complaints** you currently have:

☐ Blurred Distance ☐ Blurred Near ☐ Light sensitivity ☐ Tearing ☐ Strain

☐ Glaucoma ☐ Cataracts ☐ Nevus (freckle) ☐ Bell's Palsy ☐ Pain

☐ Flashes ☐ Floaters ☐ Dry eyes ☐ Double vision

☐ Itching ☐ Burning ☐ Glare ☐ Macular Degeneration

☐ Red eyes ☐ Lazy eye ☐ Keratoconus ☐ Astigmatism

☐ Eye injuries or surgeries________________________ ☐ Other ____________________

List your **current Medications/Vitamins**: ________________________________

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List any **Allergies**: ________________________________

Please check the following Medical / Ocular conditions in your **Family History**:

☐ Diabetes ☐ Hypertension ☐ Heart conditions ☐ Autoimmune disease

☐ High Cholesterol ☐ Glaucoma ☐ Macular Degeneration ☐ Lazy eye ☐ Blindness

☐ Retinal Disorder ☐ Cataracts ☐ Other ________________________________

Glasses History: ☐ Distance ☐ Near ☐ Progressives ☐ Bifocals

Comments/complaints: ________________________________

Contact Lens History: Comments/complaints: ________________________________

Brand & Prescription:________________________________

Oakland Vision Center Doctor's Office
350 Ramapo Valley Rd
Oakland, NJ 07436

We are now offering **Optical Coherence Tomography (OCT)** to all of our patients as a prophylactic measure of ocular health. OCT is a new, completely painless and highly advanced screening system that checks for potentially serious conditions such as glaucoma, diabetes, age-related macular degeneration, vitreous detachments and more. OCT sees beneath the surface of the eye where signs of eye diseases first appear. This screening is suggested at routine eye exams annually.

Upon receiving a vision exam/using vision insurance, the charge for OCT testing is $39. If medical insurance is used, the service will be a claim billed to your insurance company.

*******Please **initial** if you would like to have this testing done today ___________

Please read the following carefully, **initial** after each statement and **sign below**. Please feel free to ask the front desk staff any questions;

To determine when **vision or medical insurance** is used on a given visit depends on the purpose of the visit and the patient's health conditions. A Vision Exam is recommended every year. This purpose is to check the health of the eye as well as to provide an eyeglass and/or contact lens prescription if needed. A Medical Exam is performed to evaluate any abnormal findings, and to monitor existing medical conditions. _____________ **Initial**

I authorize Oakland Vision Center Doctor's Office to furnish information to insurance carriers, outside physicians, or legal guardians concerning my health conditions and treatments, or insurance information needed for related claims, or associated with my insurance company's Quality Assurance Program. _____________ **Initial**

It is my responsibility to obtain a referral or pre-authorization when required, and it must be presented to the office upon check-in. If later my insurance company determines that I was required a referral for payment of service and one was not provided, I am responsible for the customary charges for the visit(s). _____________ **Initial**

I am responsible for determining my insurance company's coverage of services provided at Oakland Vision Center Doctor's Office. If my insurance company determines any portion of a visit is "not a covered service", I am responsible for the non-payment portion of that claim. Commonly when medical insurance is used for a routine visit, the **Refraction** portion of the exam will not be covered and there is a $39 fee. In addition, **Contact lens prescriptions** expire annually and require an annual Contact lens exam. Most insurances do NOT cover the cost of contact lens exams. _____________ **Initial**

I am responsible for determining if I have met my **deductible** contracted with my insurance company. If I have not met my deductible, I am responsible for paying the amount that went towards my deductible to Oakland Vision Center Doctor's Office. _____________ **Initial**

If I have a **copayment** contracted with my insurance company, that amount is required to be paid at all office visits. This includes follow-up visits, or discussions of questions regarding my medical or vision conditions. _____________ **Initial**

If my insurance company delays payment for services beyond 60 days from initial submission of claim, I am responsible for payment of the charge for the visit. _____________ **Initial**

Signature ____ Date _______________