

Dr. Michael Onyon and Associates
GENERAL QUESTIONNAIRE

Please print: Date _____
Name _____ Nickname _____
Street _____ City _____
State _____ Zip _____ Email address _____
Social Security No. _____ Home Phone (____) _____
Cell Phone (____) _____ Work Phone (____) _____
Date of Birth ____/____/____ Occupation _____
Sex: Male _____ Female _____ Marital Status: Single _____ Married _____ Other _____
Are you here for: () eyeglasses () contact lenses () other: _____

Name of Primary Care Physician: _____ Phone #: _____

Last Physical Exam ____/____/____ Last Eye Exam ____/____/____

Medical/Vision Insurance:

Medical _____ I.D.# _____ Copay \$ _____

Vision _____ I.D.# _____ Copay \$ _____

*Your signature below signifies that you authorize Dr. Michael J. Onyon and Associates, P.C. to bill your **primary** insurance carrier or vision plan for services rendered; you authorize the insurance company or vision plan to pay Dr. Michael J. Onyon and Associates, P.C. all benefits due; and you agree to assume responsibility for all charges not covered by the **primary** insurance company or vision plan. Correct insurance and vision plan information must be provided at the time services are rendered or orders are placed if you wish us to submit a claim to your plan or insurance company or apply benefits.*

How did you find out about us? () walked by () phone book () friend () relative
Other () _____ If friend or relative please indicate who: _____

DIGITAL RETINAL SCREENING

Salem Vision Center, committed to providing the best patient care possible, offers high resolution digital retinal imaging. This new technology allows more detailed examination and documentation of the health of your eyes, and assists the doctor in early detection of many disorders, including cataracts, glaucoma, macular degeneration, retinal detachments, high blood pressure, and diabetes, **before they can be otherwise detected.** This procedure is as fast as taking a picture. **IT DOES NOT REQUIRE DILATION DROPS**, thus eliminating 30 minutes of exam time, and avoids blurry near-vision and light sensitivity. It is not covered by insurance for routine eye exams.

_____ I **DO** want digital retinal imaging and agree to the charge of \$ 42.00.

_____ I **DO NOT** want the procedure performed.

PRIVACY POLICY

This office complies with state and federal privacy laws. A copy of our notice of privacy practices is available upon request. Check here if you wish to receive a copy.

Patient or Guardian Signature _____ Date _____