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_____/_____/_____

Health/Vision Insurance:

Primary_____ I.D.#_____Copay $_____

Secondary_____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, often without dilation, and assists the doctor in early detection of many disorders, including cataracts, glaucoma, macular degeneration, retinal detachments, and other vision threatening conditions, **before they can be otherwise detected.** This procedure is NOT covered by insurance when used as a screening device and is available at a charge of only $ 35.00. We are very impressed with the results of this technology and highly recommend digital retinal imaging as part of your examination. Please indicate your preference below.

_____ I **DO** want digital retinal imaging and agree to the charge of $ 35.00.

_____ 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_____