ALAN D. MONTGOMERY, O.D.

ELIZABETH WOLFF, O.D., F.A.A.O.

MICHAEL SPENCER, O.D.

SALEM EYE CLINIC LLC

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip _____ Email: _____

Birthdate: _____ Preferred Method of Contact: (circle one)

Social Security #: _____ Home Cell Text Email Mail

Medical Physician: _____ Preferred Pharmacy: _____

_____ _____ _____

Emergency Contact Emergency Phone Relationship

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Height: _____ Weight: _____

_____ _____ _____

Occupation Employer/School Employer Phone #

Please Circle:

Race: Unknown American Indian or Alaska Native Asian Black or African American White

Native Hawaiian other Pacific Islander Other Race

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Please list medications and dosage:

Review of Systems: Please check all that apply and explain

- Constitution (eg: Cancer, developmental disabilities, fatigue syndrome) Please explain:

  _____

- Ear Nose Throat (eg: Sinusitis, dry mouth, hearing loss) Please explain:

  _____

- Neurological (eg: Tumor, migraine, MS) Please explain:

  _____

- Psychiatric (eg: Anxiety, depression, bipolar) Please explain:

  _____

- Cardiovascular (eg: Hypertension, stroke, heart disease, cholesterol) Please explain:

  _____

- Respiratory (eg: Asthma, emphysema, sleep apnea) Please explain:

  _____

- Gastrointestinal (eg: Crohn's, acid reflux, ulcer) Please explain:

  _____

- Genitourinary (eg: Kidney disease, prostate disease, STD) Please explain:

  _____

- Musculoskeletal (eg: Arthritis, osteoporosis, gout) Please explain:

  _____

- Skin Issues (eg: Herpes, psoriasis, eczema) Please explain:

  _____

- Endocrine (eg: Diabetes type I or II, thyroid, hormonal dysfunction) Please explain:

  _____

- Hematologic/Lymphatic System (eg: Anemia, large volume blood loss, ulcer) Please explain:

  _____

- Allergy/Immunologic (eg: Allergies, rheumatoid arthritis, Sjogren's syndrome) Please explain:

  _____

- Pregnant or Nursing:

  _____

Please list any surgeries and dates:

_____

_____

_____

_____

_____

_____

Facility Director

While you are at our office, if we receive a telephone call from someone asking if you are here or would like to talk to you, do you want us to acknowledge to the caller that you are here? Yes or No

Contact Record:

We may call or write to remind you of your scheduled appointments, or that it is time to make an appointment. We may also call or write to notify you of referral information or test results, as well as other treatments or services available at our office that might help you.

Is it okay to leave a message on your answering machine/voicemail Yes or No

or with the person who answers the phone? Yes or No

Insurance:

Do you have vision insurance? Yes or No If yes, Insurance Carrier: _____

Do you have medical insurance? Yes or No If yes, Insurance Carrier: _____

If Medicare do you have a Supplemental? Yes or No If yes, Insurance Carrier: _____

Salem Eye Clinic is not a provider for all insurance carriers. Please check that your carrier is covered before your appointment.

Contact Lens Notice

Are you interested in contact lenses? Yes or No

If yes, a fitting fee and follow up visits will be required before a contact lens prescription can be issued.

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! **Please understand that financial responsibility for your account is yours, NOT your insurance company's.**

I authorize the release of any vision or medical insurance information necessary to process insurance claims to the physician or supplier of the service.

I authorize payment of medical benefits to the physician or supplier for services.

I hereby acknowledge that I have been informed that Medicare will not pay for "non-covered" services or materials, or for routine care that does not involve specific problem-oriented complaints. I understand that I will be personally responsible for payment of all non-covered services as determined by Medicare.

I understand that Medicare will not pay for the refractive portion of the eye examination (the portion of the exam that the doctor is determining the prescription), nor will they cover the 20% co-pay on the covered portion of the examination, nor the yearly deductible. **Medicare will not pay for routine care such as a recall exam where there is no medical complaint.**

I have read the above and acknowledge that I have been offered a copy of Salem Eye Clinic's Notice of Privacy Practices.

SIGNED: _____ DATE: _____