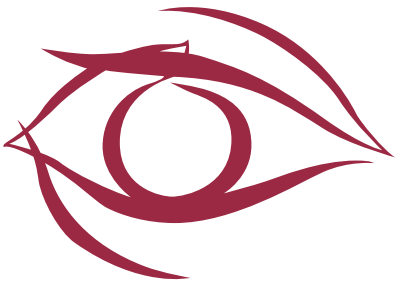


Vistar Eye Center®

Vision & Surgery Specialists

Vistar Eye Center®
Vision & Surgery Specialists

EYE M.D.'s

CHAD D. ALBRIGHT, M.D.
CATARACT & LENS IMPLANT SURGERY
COMPREHENSIVE OPHTHALMOLOGY
LASIK & REFRACTIVE SURGERY

JON P. BRISLEY, M.D.
MANAGING PARTNER
COMPREHENSIVE OPHTHALMOLOGY
CATARACT & LENS IMPLANT SURGERY

TIMOTHY R. BYRNES, M.D.
DISEASES & SURGERY OF THE RETINA

FRANK COTTER, M.D.
GLAUCOMA CONSULTANT
CATARACT & LENS IMPLANT SURGERY

JOHN M. FACCIANI, M.D.
PEDIATRIC OPHTHALMOLOGY
STRABISMUS SURGERY
LASIK & REFRACTIVE SURGERY

KURT W. L. GUELZOW, M.D.
COMPREHENSIVE OPHTHALMOLOGY
EYE PLASTIC & RECONSTRUCTIVE SURGERY

CRAIG D. HARTRANFT, M.D.
DISEASES & SURGERY OF THE RETINA

JOHN L. HINES, M.D.
DISEASES & SURGERY OF THE RETINA

DAVID A. KINSLER, M.D.
CATARACT & LENS IMPLANT SURGERY
LASIK & REFRACTIVE SURGERY

ANN B. SOWERS, M.D.
COMPREHENSIVE OPHTHALMOLOGY
PEDIATRIC OPHTHAL. & STRABISMUS

SCOTT A. STRELOW, M.D.
CORNEA & LASIK SURGERY
CATARACT & LENS IMPLANT SURGERY

KENNETH D. TUCK, M.D.
COMPREHENSIVE OPHTHALMOLOGY
ANTERIOR SEGMENT SURGERY

JOHN R. WOOD, M.D.
CATARACT & LENS IMPLANT SURGERY
ANTERIOR SEGMENT SURGERY
COMPREHENSIVE OPHTHALMOLOGY

OPTOMETRISTS

CHARLES C. PEGRAM JR., O.D.
EYE DISEASES
CONTACT LENSES

D. MAC SCOTHORN, O.D.
EYE DISEASES
CONTACT LENSES, CRT, LOW VISION

ORTHOPTIST

TABITHA WALKER, C.O., C.O.M.T.
CERTIFIED ORTHOPTIST

PAUL LEVY, C.E.O.
CHIEF EXECUTIVE OFFICER

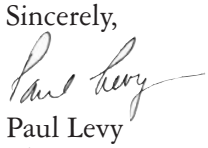
Thank you for choosing Vistar Eye Center for your eye care needs.

To better serve you, we have compiled a list of items to prepare for your first visit.

- Enclosed are registration and history forms to complete, sign as indicated and <u>bring with you to our office on the day of your visit.</u>
- **Existing patients** please arrive 15 minutes before your scheduled appointment time.
- **New patients** please arrive 30 minutes before your scheduled appointment time.
- Bring a list of all your current medications or medication containers on the day of your first visit.
- **Bring your insurance card(s), along with your photo ID, to your visit in order for us to file your insurance for you.** We participate in Medicare, Medicaid, and Anthem along with other insurance carriers.
- **If your insurance requires a referral, please obtain this prior to your visit. If you do not have the required referral, you will need to either reschedule your appointment or be prepared to pay for services rendered at the time of the visit.** We accept personal checks, cash, VISA and MasterCard.
- A complete eye exam includes dilation that causes glaring and blurred vision after the visit. If you have safety concerns, please make arrangements to have someone with you.
- Children's eye exams take longer than adults. Please plan to be here for two hours for your child's dilated exam.
- Should you need to cancel your appointment for any reason, please notify our office at least 24 hours in advance to avoid a possible no-show charge being added to your account.
- Patients with either mental or physical handicaps must be accompanied by an adult. If needed, please remember to bring a copy of your power of attorney letter.

Thank you for allowing our doctors and staff to assist you with your eye care needs. We at Vistar Eye Center recognize how vital eyesight is to your overall health. Please visit our website at <u>www.vistareye.com</u> to learn more about our doctors and services.

Sincerely,



Paul Levy
Chief Executive Officer

For Appointments Call **540-855-5100** Toll Free **866-615-5454**
www.vistareye.com

OFFICES LOCATED AT:

CORPORATE OFFICE
2802 BRANDON AVENUE, SW
ROANOKE, VA 24015
540-344-4000

3320 FRANKLIN RD. SW
ROANOKE, VA 24014
540-344-4000

707 S. JEFFERSON ST.
ROANOKE, VA 24016
540-344-4000

375 HERSHBERGER RD.
ROANOKE, VA 24012
540-344-4000

5296 PETERS CREEK RD.
ROANOKE, VA 24019
540-342-3400

70 SUMMERFIELD COURT
ROANOKE, VA 24019
540-344-4000

548 BLUE RIDGE AVE.
BEDFORD, VA 24523
540-586-5700

426 W. MAIN ST.
SALEM, VA 24153
540-344-4000

Vistar Eye Center, Inc. • PO Box 1789, Roanoke, Virginia 24008 • 540-855-5100

PATIENT INFORMATION

Name(Last, First, Middle)	SSN	Birthdate	Sex	Marital Status

Race *	Preferred Language *	Ethnicity *

Local Address	City	State	Zip

Home Phone	Day Phone	E-mail address ☐ refused ☐ do not have

Primary Care Physician	Address	Phone

Referring Physician	Address	Phone

Pharmacy (name and location)	Emergency Contact	Phone	Relationship

RESPONSIBLE PARTY INFORMATION (If different from above)

Name (Last, First, Middle)	Birth date	Sex

Billing Address	City, State, Zip

Home Phone	Day Phone	Relationship to Patient

PRIMARY INSURANCE

Name of Insurance Company		Policy #	
Member Name on Card	Member Birth Date	Group #	
Employer	Address	Phone	
Relationship to Patient		Effective Date	Expiration Date

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Policy #	
Member Name on Card	Member Birth Date	Group #	
Address of Insurance Company		Co-Pay Amount $	
City, State, Zip	Phone Number	Deductible $	
Relationship to Patient		Effective Date	Expiration Date

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services, I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Patient/Guardian _____ Date _____

If patient is a minor: I give permission for my child to have any diagnostic drops or contact lens service which are required for an eye exam or contact lens fitting.

Signature of Patient/Guardian _____ Date _____

_____ **INITIAL** I understand that Vistar Eye Center will only use my email to communicate information regarding general eye care, promotions or other Vistar Eye marketing information. Vistar Eye Center will not sell or distribute patient emails to a third party.

_____ **INITIAL *** New government regulations require Vistar/Health Entities to request Race, Preferred Language, & Ethnicity. Should you prefer not to provide this information, please initial.

DEEMED CONSENT TO HIV TESTING: In case a health care worker of this Clinic should be stuck by a needle or is directly exposed to fluids during your care which may transmit HIV virus, in accordance with Section 32.1-37.2 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing of the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposures.

Signature of Patient/Guardian _____ Date _____

LAST NAME FIRST MI AGE TODAY'S DATE

PAST MEDICAL HISTORY

List your current eye meds:

List your current prescription and over the counter medications:

	Y	N	
Do you have any allergies to any medications?	☐	☐	List any:
Do you have an allergy to latex?	☐	☐	List any:

List any previous eye surgery/eye injuries:

List previous major surgery:

SOCIAL HISTORY

	Y	N			Y	N
Do you smoke?	☐	☐	How many packs?	Have you ever been exposed to hepatitis or a sexually transmitted disease?	☐	☐
Do you drink alcohol?	☐	☐	How often?			
Have you ever had a blood transfusion?	☐	☐	When?	Occupation		

FAMILY HISTORY

	Y	N	Which relatives(s)?		Y	N	Which relatives(s)?
Cataract	☐	☐		Diabetes	☐	☐	
Retinal Detachment	☐	☐		Macular degeneration	☐	☐	
Glaucoma	☐	☐		Blindness (any cause)	☐	☐	

REVIEW OF SYSTEMS

Have you recently had any of the following problems?

Constitutional:	Y	N	**Respiratory**	Y	N	**Gastrointestinal:**	Y	N	**Other:**
Fever	☐	☐	Asthma	☐	☐	Colitis	☐	☐	
Weight loss	☐	☐	Bronchitis	☐	☐	Ulcers	☐	☐	
Excessive fatigue	☐	☐	Emphysema	☐	☐	Cancer	☐	☐	

Eyes:	Y	N	**Cardiovascular:**	Y	N	**Musculoskeletal:**	Y	N
Blurred vision	☐	☐	Chest pain	☐	☐	Arthritis	☐	☐
Loss of vision	☐	☐	Irregular heart rate	☐	☐	Skin disorders	☐	☐
Eye irritation	☐	☐	High blood pressure	☐	☐	Blood diseases	☐	☐
			Heart attack	☐	☐			

Ears, nose & throat:	Y	N	**Endocrine:**	Y	N
Sinus problems	☐	☐	Diabetes	☐	☐
Chronic cough	☐	☐	Thyroid imbalance	☐	☐

Neurologic:	Y	N	**Psychiatric:**	Y	N
Seizures	☐	☐	Depression	☐	☐
Stroke	☐	☐			

Physician: _____ Reviewed on: _____ (date)