# MEDICAL INFORMATION SHEET

**Wheelchair:** Can Transfer **YES NO**

**Stretcher:** Can Transfer **YES NO**

_____

**Last Name** **First Name** **MI** **DOB** **Today's Date**

**Family Doctor:**_____ **Referring Doctor:**_____

**Preferred Pharmacy (name and location):** _____

## EYE HISTORY/MEDICATIONS

**List your current eye medications:**

_____
_____
_____
_____
_____

**Have you had?**

- ☐ **Cataract Surgery**
- ☐ **Glaucoma Surgery**
- ☐ **Retina Surgery**
- ☐ **Muscle Surgery**
- ☐ **Vision Correction (LASIK/RK)**
- ☐ **Other**_____

**List any eye diseases you have:**_____
_____

## MEDICATIONS/ALLERGIES

**List all prescription and over-the-counter medications, or attach list:**

_____ _____
_____ _____
_____ _____
_____ ☐ **SEE ATTACHED LIST**

**Do you have allergies to medications?**

**YES NO**

**If yes, please list:** _____
_____

**Allergic to Latex?:** **YES NO**

## FAMILY HISTORY

**Which Relatives? (mother/father/sibling, etc.)**

- ☐ **Cataract:** _____ __ ___
- ☐ **Diabetes:** _____ __ ___
- ☐ **Retinal Detachment:** _____
- ☐ **Glaucoma:** _____
- ☐ **Macular Degeneration:**_____
- ☐ **Blindness:** _____

## SOCIAL HISTORY

**Do you consume any of the following?**

| | | | |
|---|---|---|---|
| **Alcohol** | **NO** | **YES** | type:_____ |
| **Caffeine** | **NO** | **YES** | amount:_____ |
| **Tobacco** | **NO** | **YES** | how much:_____ |

## PERSONAL MEDICAL HISTORY

| **Neurological** | **Y** | **N** |
|---|---|---|
| Parkinson's | ☐ | ☐ |
| Seizure Disorder | ☐ | ☐ |
| Stroke/TIA | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| **Respiratory** | **Y** | **N** |
| Asthma | ☐ | ☐ |
| Bronchitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| COPD | ☐ | ☐ |
| **Musculoskeletal** | **Y** | **N** |
| Arthritis | ☐ | ☐ |
| Rheumatoid | ☐ | ☐ |

| **Cardiovascular** | **Y** | **N** |
|---|---|---|
| Irregular Heart rate | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| **Endocrine** | **Y** | **N** |
| Diabetes | ☐ | ☐ |
| Thyroid Imbalance | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| **Gastrointestinal** | **Y** | **N** |
| Colitis | ☐ | ☐ |
| Ulcers | ☐ | ☐ |

| **Psychiatric** | **Y** | **N** |
|---|---|---|
| Depression | ☐ | ☐ |
| Dementia | ☐ | ☐ |
| Alzheimer's | ☐ | ☐ |
| **Other** | **Y** | **N** |
| HIV | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Lupus | ☐ | ☐ |
| MS | ☐ | ☐ |
| MRSA | ☐ | ☐ |
| STD | ☐ | ☐ |
| Cancer | ☐ | ☐ |

Type: _____

**List all major surgeries:**

_____
_____
_____
_____
_____
_____
_____
_____

**#001 06/19**

CHAD ALBRIGHT, M.D.
Cataract Surgery

ROMULO ALBUQUERQUE, M.D.
Vitreoretinal Medicine & Surgery

JON BRISLEY, M.D.
Managing Partner
Comprehensive Ophthalmology

TIMOTHY BYRNES, M.D.
Vitreoretinal Medicine & Surgery

FRANK COTTER, M.D.
Glaucoma & Cataract Surgery

JOHN FACCIANI, M.D.
Pediatric Ophthalmology & Surgery

KARLI GRIFFETH, M.D.
Cataract & Refractive Surgery

WILL GRIFFETH, M.D.
Cataract & Refractive Surgery

CRAIG HARTRANFT, M.D.
Vitreoretinal Medicine & Surgery

VISHAK JOHN, M.D.
Vitreoretinal Medicine & Surgery

DAVID KINSLER, M.D.
Cataract & Refractive Surgery

MICHAEL MCCLINTOCK, JR., M.D.
Vitreoretinal Medicine & Surgery

NICHOLAS RAMEY, M.D.
Oculofacial & Cosmetic Surgery

TAD SCHOEDEL, M.D.
Glaucoma & Cataract Surgery

SCOTT STRELOW, M.D.
Cornea & Cataract Surgery

STUART TIMS, M.D.
Cornea, Cataract & Refractive Surgery

BRUCE WATSON, M.D.
Pediatric Ophthalmology

EMMA-CATHERINE ALI, O.D.

MEGAN ANDREWS, O.D.

REAGAN DARNER, O.D.

STEVEN HOSMAN, O.D.

ERIN MCCABE, O.D.

DONALD SCOTHORN, O.D.

CHRISSY HODGE, P.A.

Vistar Eye Center
Vision & Surgery Specialists

My name is Herbert Pierce, CEO of Vistar Eye Center and I want to welcome you to our practice. I am pleased you have chosen our team of dedicated physicians to provide for your eye care.

To ensure that you have an optimal experience when you visit, we have enclosed a checklist of essential items to bring with you. In addition, we have found it helpful to provide some details about what you can expect during your exam as well as how long it may take. Please take a moment to read these over carefully.

I am very proud of the team we have assembled to serve you and know that we take great pride in making your experience a pleasant one. Please do not hesitate to reach out to any member of the Vistar team should you have any questions or concerns.

We know there are few things more precious than your eyesight and we value the trust you have placed in us. Thank you for choosing Vistar Eye Center. For additional information about our physicians or the services we offer, please visit our website at www.VistarEye.com.

Sincerely,

Herbert Pierce
Chief Executive Officer
Vistar Eye Center

For Appointments Call: 540.855.5100 | Toll Free: 866.615.5454 | VistarEye.com

CORPORATE OFFICE
1819 ELECTRIC ROAD, SUITE 1B
ROANOKE, VA 24018
Offices Located in Roanoke, Salem, Botetourt, Smith Mountain Lake, Rocky Mount, Blacksburg, Martinsville, and Wytheville. Additional Satellite Offices throughout Southwest Virginia.

# *How to Prepare For and*

# *What to Expect at Your Appointment*

## Items to bring with you:

1. Enclosed registration and history forms. Please complete them prior to your arrival.
2. Your insurance card(s).
3. A photo ID.
4. A list of all current medications or bring the prescription containers.
5. Current glasses and contact lenses

## Checking in for your appointment:

- Please arrive 20 minutes before your scheduled appointment to allow our team of patient service specialists to register you in our computer system, verify insurance, and obtain your signature on patient consent forms.
- Please obtain any necessary referrals prior to the visit. If we do not have the required referral we will need to reschedule the appointment or, if you prefer, we can collect payment for services rendered at the time of the visit. We accept cash, checks, and major credit cards.
- If using a Vision Plan, please check with the vision carrier to ensure the provider is in-network.
- 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.

## Your eye exam:

- Allow at least 1 ½ hours for your visit.
- Results of the exam may require additional testing. These tests may lengthen your visit. Or it may be necessary to schedule another appointment.
- Pediatric exams take longer than adult exams. Please plan to be here a minimum of two hours for your child's dilated exam.
- A complete eye exam includes **dilating the pupils** which can cause glaring and blurred vision after the visit. If you are concerned about driving, you might want to make arrangements to have someone with you.
- Patients with mental or physical handicaps must be accompanied by an adult caregiver for the duration of the visit. If needed, please bring a copy of your medical power of attorney letter.
- If you need an interpreter (foreign language, ASL, etc.) please let us know ahead of your visit.

Vistar Eye Center, Inc.
PO Box 1789
Roanoke, VA 24008
(540) 855-5100

| PATIENT INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| **NAME** (Last, First Middle) | **MRN** | **SSN#** | **BIRTH DATE** | **LANGUAGE *** | **SEX** | |
| **ADDRESS** | **CITY, STATE ZIP** | **MARITAL STATUS** | **ETHNICITY *** | **RACE *** | | |
| | | | | | | |
| **HOME PHONE** | **DAY PHONE** | **EMAIL ADDRESS** | **EMERGENCY CONTACT NAME** | | | |
| | | | | | | |
| **PRIMARY CARE PROVIDER** | **Emergency Contact Number** | | | | | |
| **REFERRING DOCTOR:** | | | | | | |
| PRIMARY EMPLOYER | WORK PHONE | | | | | |
| ADDRESS | CITY, STATE ZIP | | | | | |

| RESPONSIBLE PARTY INFORMATION (If Different Than Above) | | | |
|---|---|---|---|
| NAME (Last, First Middle) | SSN# | BIRTH DATE | SEX |
| ADDRESS | CITY, STATE ZIP | | |
| HOME PHONE | DAY PHONE | RELATIONSHIP TO PATIENT | |

| PRIMARY INSURANCE | | |
|---|---|---|
| NAME OF INSURANCE COMPANY | POLICY# | |
| | | |
| NAME OF INSURED | GROUP# | |
| RELATIONSHIP TO PATIENT | EFFECTIVE DATE | EXPIRATION DATE |
| SECONDARY INSURANCE (If Applicable) | | |
| NAME OF INSURANCE COMPANY | POLICY# | |
| | | |
| NAME OF INSURED | GROUP# | |
| RELATIONSHIP TO PATIENT | | |

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

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

I also give Vistar Eye Center permission to leave a message(s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc. and are unable to reach me in any other way. _____ YES _____ NO

DEEMED CONSENT TO HIV TESTING: In accordance with Section 32.1-45.1 of the Code of Virginia, in the event any health care provider or any person employed by or under the direction of a health care provider, is directly exposed to my body fluids in a manner that may transmit HIV, or Hepatitis B or C, I understand that I shall be deemed to have consented to testing for the same viruses. In addition, I understand that I shall be deemed to have consented to the release of those test results to the person who was exposed. I also consent to the release of those results to Vistar Eye Center as the health care provider.

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.

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

_____ _____

**SIGNATURE OF PATIENT/GUARDIAN** **DATE**