



CHAD ALBRIGHT, M.D.  
ROMULO ALBUQUERQUE, M.D., Ph.D.  
TIMOTHY BYRNES, M.D.  
JENNIFER COBEN, M.D.  
FRANK COTTER, M.D.  
JOHN FACCIANI, M.D.  
KARLI GRIFFETH, M.D.  
WILL GRIFFETH, M.D.  
JUSTIN HARVEY, M.D.  
VISHAK JOHN, M.D.  
KEVIN LOWDER, M.D.  
ANNA MACKIN, M.D.  
MICHAEL MCCLINTOCK, JR., M.D.  
CHRISTINA MCKENNA, M.D.  
ERIC PETERSON, M.D.  
NICHOLAS RAMEY, M.D.  
TAD SCHOEDEL, M.D.  
BRYAN STRELOW, M.D.  
STUART TIMS, M.D.  
  
EMMA-CATHERINE ALI, O.D.  
MEGAN ANDREWS, O.D.  
MATTHEW CASEY, O.D.  
BROOKE CONNER-TSANG, O.D.  
REAGAN DARNER, O.D.  
STEVEN HOSMAN, O.D.  
JACOB LIKUS, O.D.  
KRISTEN PIERY, O.D.  
DONALD SCOTHORN, O.D.  
ELIZABETH SMITH, O.D.

Welcome to Vistar Eye Center! As Vistar's Chief Executive Officer, I am both honored and humbled that you have chosen us for your eye care needs. Our team of highly skilled doctors and dedicated support staff is committed to providing you with exceptional care and ensuring your experience is comfortable and stress-free.

To help you prepare for your first visit, we have included a checklist of essential items to bring with you. This will make your appointment as smooth and efficient as possible. You'll also find information on what to expect during your initial visit, so you can feel confident and informed every step of the way.

If you have any questions or need assistance before your appointment, please don't hesitate to reach out. You can contact us by telephone or visit our website ([www.vistareye.com](http://www.vistareye.com)) for additional resources and support.

Thank you for trusting Vistar Eye Center with your vision care. We look forward to seeing you soon!

Most sincerely,

Jon K. Bonadies, MBA, CMPE, ACHE  
Chief Executive Officer

540.855.5100 | Toll Free: 866.615.5454 | [VistarEye.com](http://VistarEye.com)

CORPORATE OFFICE

1819 ELECTRIC ROAD, SUITE 1B  
ROANOKE, VA 24018

# ***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**

# 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  Muscle Surgery  
 Glaucoma Surgery  Vision Correction (LASIK/RK)  
 Retina Surgery  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

## SOCIAL HISTORY

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

Do you consume any of the following?

Cataract: \_\_\_\_\_  Glaucoma: \_\_\_\_\_  
 Diabetes: \_\_\_\_\_  Macular Degeneration: \_\_\_\_\_  
 Retinal Detachment: \_\_\_\_\_  Blindness: \_\_\_\_\_

Alcohol NO YES type: \_\_\_\_\_  
 Caffeine NO YES amount: \_\_\_\_\_  
 Tobacco NO YES how much: \_\_\_\_\_

## PERSONAL MEDICAL HISTORY

<b>Neurological</b>	Y N	<b>Cardiovascular</b>	Y N	<b>Psychiatric</b>	Y N
Parkinson's	<input type="checkbox"/> <input type="checkbox"/>	Irregular Heart rate	<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Dementia	<input type="checkbox"/> <input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/> <input type="checkbox"/>	Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Alzheimer's	<input type="checkbox"/> <input type="checkbox"/>
Migraines	<input type="checkbox"/> <input type="checkbox"/>	<b>Endocrine</b>	Y N	<b>Other</b>	Y N
<b>Respiratory</b>	Y N	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	HIV	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Imbalance	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>	High Cholesterol	<input type="checkbox"/> <input type="checkbox"/>	Lupus	<input type="checkbox"/> <input type="checkbox"/>
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	<b>Gastrointestinal</b>	Y N	MS	<input type="checkbox"/> <input type="checkbox"/>
COPD	<input type="checkbox"/> <input type="checkbox"/>	Colitis	<input type="checkbox"/> <input type="checkbox"/>	MRSA	<input type="checkbox"/> <input type="checkbox"/>
<b>Musculoskeletal</b>	Y N	Ulcers	<input type="checkbox"/> <input type="checkbox"/>	STD	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>			Cancer	<input type="checkbox"/> <input type="checkbox"/>
Rheumatoid	<input type="checkbox"/> <input type="checkbox"/>			Type: _____	

List all major surgeries:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_