VISTARR™
LASER & VISION
CENTERS

Date_____

Patient Registration

{ } New { } Update

Name_____ Date of Birth_____
Last First Middle

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Sex M F Marital Status_____ Email_____

Emergency Contact Name_____ Phone_____

Responsible Party/Primary Insurance Subscriber: (if other than patient)

Subscriber Name_____ Subscriber Social Security #_____

Subscriber Date of Birth_____ Relationship_____

Address (if different from above)_____

Insurance Information: (Please present card(s) to receptionist)

Primary Insurance Company Name_____

ID#_____ Group#_____

Secondary Insurance (if applicable)_____

ID#_____ Group#_____

Do you have a vision plan?

Name of Vision Plan_____

ID# / SS#_____

Are you currently in Hospice or a Skilled Nursing Facility? ____Yes ____No - Hospice
____Yes ____No - SNF

I verify the information above is correct **Initials**_____ **Date**_____

Initials_____ **Date**_____

Initials_____ **Date**_____

Initials_____ **Date**_____

VISTARR™
LASER & VISION
CENTERS
Setting the Standard for Advanced Eye Care

I acknowledge that I have been offered the Notice of Privacy Practices for Vistarr Laser & Vision Centers and that I authorize the use and disclosure of health information about (name)_____for treatment, payment, and healthcare operations' purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient/Representative Date

Authorization For Release of Information and Direct Payment to the Doctor

DIRECT PAYMENT: I authorize and direct my Insurance Carrier(s) to make payments for medical or surgical treatment, injections, supplies and testing directly to Vistarr Laser & Vision Centers, I hereby authorize the submission of all information necessary to complete this claim. These authorizations shall be effective for myself and my dependents. I agree that a copy of this authorization shall be as valid as the original.

MEDICARE and MEDIGAP: I request that payment of authorized MEDICARE AND MEDIGAP benefits be made either to me or on my behalf to the physician named below for services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and any information needed to determine these benefits or the benefits payable for the related services.

I understand and agree that I am responsible for payment of all charges not fully paid by my insurance

Patient's Signature_____ Date_____

I, _____, acknowledge that I have been provided with a copy of the Notice of Privacy practices by Vistarr Laser and Vision Centers (Ophthalmic Consultants, Ltd.). I understand that I have the right to read and review the notice before signing this consent.

Patient Name: _____Date:_____
PRINT

Signature of Parent or Guardian: _____
IF MINOR OR INCAPACITATED

Signature: _____
IF PATIENT

Please complete the following: I, _____ give Vistarr Laser and Vision Centers permission to talk to ONLY the following person(s) about my medical information.

_____Myself, Only

_____My Spouse: Name _____DOB_____

_____Child(ren): Name _____DOB_____

Name _____DOB_____

_____My Caretaker: Name _____DOB_____

_____Other: Name _____DOB_____

VISTARR LASER AND VISION CENTER, 845 WEST CHESTER PIKE, WEST CHESTER, PA 19382 610-692-8100

Today's Date_____ ***It is important that you answer all questions***

Name_____ Date of Birth ____/____/____ Tech_____

Family Physician_____

PATIENT'S SOCIAL HISTORY

Marital Status	[ ] Single	[ ] Married	[ ] Divorced	[ ] Widowed
Exercise	[ ] None	[ ] Occasional	[ ] Weekly	[ ] Daily
Smoking	[ ] None	[ ] 0-1 packs/day	[ ] 1-2 packs/day	[ ] 2+ packs/day
Alcohol	[ ] None	[ ] Social	[ ] 2-3 times/week	[ ] Daily, dinner [ ] Several times/day
Do you Drive?	[ ] Yes	[ ] No		
Occupation	_____		Height_____	Weight_____
Other	_____			

PATIENT'S EYE HISTORY

	Yes	No
Cataract	[ ]	[ ]
Dry Eyes	[ ]	[ ]
Glaucoma	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Diabetic Retinopathy	[ ]	[ ]

LIST ALL PRIOR SURGERIES AND SERIOUS INJURIES: (Date & Type)

PATIENT'S FAMILY HEALTH HISTORY

S=	Sister	B=	Brother
M=	Mother	F=	Father
MA=	Maternal Aunt	PA=	Paternal Aunt
MU=	Maternal Uncle	PU=	Paternal Uncle
MGM=	Maternal Grandmother	PGM=	Paternal Grandmother
MGF=	Maternal Grandfather	PGF=	Paternal Grandfather

	Yes	No	Who
Cataracts	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	_____
Asthma	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	_____
Heart Attack	[ ]	[ ]	_____
Stroke	[ ]	[ ]	_____

PATIENT'S HEALTH HISTORY

	Yes	No
Migraines	[ ]	[ ]
Pneumonia	[ ]	[ ]
Lupus	[ ]	[ ]
Diabetes	[ ]	[ ]
Insulin Dependent	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Stroke	[ ]	[ ]
Heart Attack	[ ]	[ ]
Asthma	[ ]	[ ]
Blood Disorder	[ ]	[ ]
Cancer	[ ]	[ ]

Specify:_____

Other:_____

Allergies (Specify):

Medication:_____

Food:_____

Environmental:_____

PHYSICIAN SIGNATURE

Update: