



# Your Life. Your Vision.

## Your Time for Laser Vision Correction Is Now!



# Advanced CustomVue



## The Wait for Better Vision Is Over

The **Advanced CustomVue** Procedure is ushering in a new era in laser vision correction by giving millions of people — including many who were once told they were not candidates — the opportunity to free themselves from glasses and contact lenses. There has never been a laser vision correction procedure that offers the precision and accuracy of the **Advanced CustomVue** Procedure.

Since 2003, the **Advanced CustomVue** Procedure has continued to earn FDA approvals to treat the broadest range of vision imperfections possible, including mild to severe nearsightedness, farsightedness and all types of astigmatism.

## An Individualized Treatment

During your personal consultation with your doctor, you'll learn about the procedure and undergo testing that ensures you are a good candidate to receive the **Advanced CustomVue** Procedure.

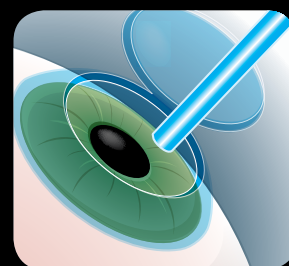


One of the tests you will undergo is a **WaveScan** System examination, which creates a map of your eyes' unique imperfections.

The **Advanced CustomVue** Procedure uses the digital information from that map to design a custom treatment for each of your eyes. **VISX** Iris Registration Technology, available only with the **Advanced CustomVue** Procedure, centers treatment correctly for a more precise treatment. The one-of-a-kind approach and technical safeguards were designed to allow the **Advanced CustomVue** Procedure to achieve exceptional visual outcomes.

## Your Procedure Day

On the day of the procedure, your doctor will place numbing drops in your eyes. The **WaveScan** map information that was taken during your previous appointment is then transferred to the **STAR S4 IR** Excimer Laser.



The laser uses this information to apply a cool laser beam that reshapes your cornea to create a new curvature and correct your vision.

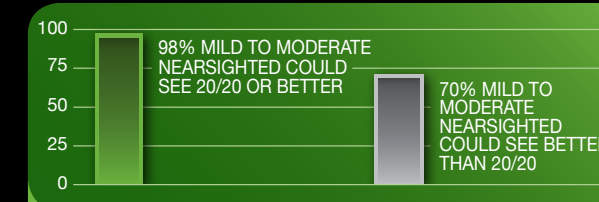
Patients usually experience immediate results, which continue to improve over the next several days. The morning following surgery, patients often wake up with a clearer view of life.

By scheduling your consultation today, you can experience better vision without the hassles of glasses and contact lenses tomorrow.

## Outstanding Results

Clinical studies presented to the FDA show that the **Advanced CustomVue** Procedure can potentially produce better vision than is possible with glasses or contact lenses.\* In fact, clinical studies have shown that more patients were satisfied or very satisfied with their vision after the **Advanced CustomVue** Procedure than they were before with glasses or contact lenses.\*

### One Year After Treatment, Results Showed:



At six months — three times as many patients were very satisfied with their night vision after treatment compared to night vision before treatment with glasses or contact lenses

Other notable outcomes for specific indications show:\*

- 98 percent of mild to moderate nearsighted patients could see **20/20 or better** one year after treatment
- 100 percent of mild to moderate nearsighted patients could pass a driving test without glasses or contact lenses one year after treatment

For more information, please visit [www.personalbestvision.com](http://www.personalbestvision.com).

\*Data on file. AMO Development, LLC. **CustomVue** Procedure clinical trials submitted to the FDA; 2003, 2004, 2005 & 2007.



### IMPORTANT SAFETY INFORMATION

Laser assisted *in-situ* keratomileusis (LASIK) can only be performed by a trained physician and is specified for reduction or elimination of myopia, hyperopia, and astigmatism as indicated within the product labeling. Laser refractive surgery is contraindicated for patients: a) with collagen vascular, autoimmune, or immunodeficiency diseases; b) who are pregnant or nursing women; c) with signs of keratoconus or abnormal corneal topography; d) who are taking one or both of the following medications: Isotretinoin (Accutane) and Amiodarone hydrochloride (Cordarone). Potential side effects to laser refractive surgery may include glare, dry eye, as well as other visual anomalies. LASIK requires the use of a microkeratome that cuts a flap on the surface of the cornea, potential side effects may include flap related complications. Consult with your eye care professional and *Patient Information Booklet* regarding the potential risks and benefits for laser refractive surgery, results may vary for each individual patient.

**Restricted Device:** U.S. Federal Law restricts this device to sale, distribution, and use by or on the order of a physician or other licensed eye care practitioner. U.S. Federal Law restricts the use of this device to practitioners who have been trained in its calibration and operation and who have experience in the surgical treatment and management of refractive errors.

#### IMPORTANT SAFETY INFORMATION

#### **VISX Wavefront-Guided LASIK for Correction of Myopic Astigmatism, Hyperopic Astigmatism and Mixed Astigmatism (CustomVue LASIK Laser Treatment)**

Statements regarding the potential benefits of wavefront-guided LASIK (**CustomVue**) are based upon the results of clinical trials. These results are indicative of not only the **CustomVue** treatment but also the care of the clinical physicians, the control of the surgical environment by those physicians, the clinical trials' treatment parameters and the clinical trials' patient inclusion and exclusion criteria. Although many clinical trial patients after the **CustomVue** Procedure saw 20/20 or better and/or had or reported having better vision during the day and at night, compared to their vision with glasses or contact lenses before the procedure, your results may vary. You can find information about the clinical trials below and in the **CustomVue Patient Information Booklet**.

Only an eye care professional trained in laser vision correction can determine whether you are a suitable candidate for the **CustomVue** Procedure. As with any surgical procedure, there are risks associated with the **CustomVue** treatment. Before deciding whether to have the **CustomVue** Procedure, you should ask your doctor for and carefully review the **CustomVue Patient Information Booklet**. It is important to discuss the risks associated with the procedure and any questions you may have about the procedure with your doctor.

#### WAVEFRONT-GUIDED LASIK INDICATIONS AND INTENDED USES (LOW TO MODERATE MYOPIC ASTIGMATISM):

The **VISX STAR S4** Excimer Laser System and **WaveScan WaveFront** System are approved to perform wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments for the reduction or elimination of low to moderate myopic astigmatism up to -6.00 D MRSE, with cylinder between 0.00 and -3.00 D in patients 21 years of age or older; and in patients with documented evidence of a change in manifest refraction of no more than 0.50 D (in both cylinder and sphere components) for at least one year prior to the date of preoperative examination. Note that the complete name for this ophthalmic laser is "**STAR S4 ActiveTrak** Excimer Laser System for wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments of myopic astigmatism up to -6.00 D MRSE, with cylinder between 0.00 and -3.00 D." An acceptable alternate version of this official name is "wavefront-guided LASIK for correction of myopic astigmatism."

Wavefront-guided LASIK is an elective procedure with the alternatives including but not limited to eyeglasses, contact lenses, photorefractive keratectomy (PRK), conventional LASIK, and other refractive surgeries. Approval of the application is based on a clinical trial of 351 eyes (189 primary and 162 secondary). Of all eyes treated, 318 were evaluated for effectiveness with 98.8% accountability at 3 months, 277 eyes with 96.9% accountability at 6 months, 102 eyes with 95.3% accountability at 9 months, and 86 eyes with 95.6% accountability at 12 months. The studies found that of the 277 eyes eligible for the uncorrected visual acuity (UCVA) analysis of effectiveness at 6 months, 100% were corrected to 20/40 or better, and 95.8% were corrected to 20/20 or better in 71 spherical myopia eyes; and 99.5% were corrected to 20/40 or better, and 93.2% were corrected to 20/20 or better in 206 astigmatic myopia eyes.

The study showed that at the 3 month stability time point: there was a loss of  $\geq 2$  lines of best corrected vision that can be obtained with spectacles in 1 of 239 astigmatic myopia eyes and there was no loss of  $\geq 2$  lines of best corrected vision in 79 spherical myopia eyes; there was 1 of 239 astigmatic myopia eyes with best spectacle corrected visual acuity (BSCVA) worse than 20/25 and none in 79 spherical myopia eyes with BSCVA worse than 20/25. During the course of study, no eye lost  $>2$  lines of BSCVA and no eye had a BSCVA worse than 20/40.

#### WAVEFRONT-GUIDED LASIK INDICATIONS AND INTENDED USES (HIGH MYOPIC ASTIGMATISM):

The **VISX STAR S4** Excimer Laser System with **VSS Refractive** Technology and **WaveScan WaveFront** System are approved to perform wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments for the reduction or elimination of high myopic astigmatism from -6.00 D to -11.00 D MRSE, with cylinder between 0.00 and -3.00 D in patients 21 years of age or older; and in patients with documented evidence of a change in manifest refraction of no more than 1.00 D (in both cylinder and sphere components) for at least one year prior to the date of preoperative examination. Note that the complete name for this ophthalmic laser is "**STAR S4 IR** Excimer Laser System for wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments of myopic astigmatism from -6.00 to -11.00 D MRSE, with cylinder between 0.00 and -3.00 D." An acceptable alternate version of this official name is "wavefront-guided LASIK for correction of high myopia with or without astigmatism."

Wavefront-guided LASIK for correction of high myopic astigmatism is an elective procedure with the alternatives including but not limited to eyeglasses, contact lenses, photorefractive keratectomy (PRK), conventional LASIK, and other refractive surgeries. Approval of the application is based on a clinical trial of 184 eyes. Of all eyes treated, 180 were evaluated for effectiveness with 97.8% accountability at 3 months, 178 eyes with 96.7% accountability at 6 months, 170 eyes with 96.5% accountability at 9 months, and 107 eyes with 93.9% accountability at 12 months. The studies found that of the 178 eyes eligible for the uncorrected visual acuity (UCVA) analysis of effectiveness at 6 months, 98.3% were corrected to 20/40 or better, 97.2% were corrected to 20/32 or better, and 84.3% were corrected to 20/20 or better without spectacles or contact lenses. The study showed that of 83 spherical and 101 astigmatic eyes, no eyes lost 2 or more lines of best corrected vision that can be obtained with spectacles (BSCVA) and none of the eyes had BSCVA worse than 20/40.

#### WAVEFRONT-GUIDED LASIK INDICATIONS AND INTENDED USES (HYPEROPIC ASTIGMATISM):

The **VISX STAR S4** Excimer Laser System and **WaveScan WaveFront** System are approved to perform wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments for the reduction or elimination of hyperopic astigmatism up to +3.00 D MRSE, with cylinder between 0.00 and +2.00 D in patients 21 years of age or older; and in patients with documented evidence of a change in manifest refraction of no more than 1.0 D (in both cylinder and sphere components) for at least one year prior to the date of preoperative examination. Note that the complete name for this ophthalmic laser is "**STAR S4 ActiveTrak** Excimer Laser System for wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments of hyperopic astigmatism up to +3.00 D MRSE, with cylinder between 0.00 and +2.00 D." An acceptable alternate version of this official name is "wavefront-guided LASIK for correction of hyperopic astigmatism."

Wavefront-guided LASIK for hyperopic astigmatism is an elective procedure with the alternatives including but not limited to eyeglasses, contact lenses, photorefractive keratectomy (PRK), conventional LASIK, and other refractive surgeries. Approval of the application was based on a clinical trial of 144 eyes (74 primary and 70 secondary). Of all eyes treated, 134 were evaluated for effectiveness with 98.5% accountability at 3 months, 131 eyes with 97.0% accountability at 6 months, 118 eyes with 90.8% accountability at 9 months, and 27 eyes with 87.1% accountability at 12 months. The studies found that of the 131 eyes eligible for the uncorrected visual acuity (UCVA) analysis of effectiveness at 6 months, 97.3% were corrected to 20/40 or better, and 66.2% were corrected to 20/20 or better in 74 spherical hyperopia eyes; and 93.0% were corrected to 20/40 or better, and 56.1% were corrected to 20/20 or better in 57 astigmatic hyperopia eyes.

The study showed that at the 6 month stability time point: there was no loss of  $\geq 2$  lines of best corrected vision that can be obtained with spectacles in 1 of 239 astigmatic myopia eyes and there was no loss of  $\geq 2$  lines of best corrected vision that can be obtained with spectacles in either 63 astigmatic hyperopia eyes or 74 spherical hyperopia eyes; none of the 63 astigmatic hyperopia or 74 spherical hyperopia eyes had best spectacle corrected visual acuity (BSCVA) worse than 20/25. During the course of the study, one in 63 eyes with astigmatic hyperopia lost  $>2$  lines of BSCVA at 1 month, no eyes with spherical hyperopia lost  $>2$  lines of BSCVA, and no eye had a BSCVA worse than 20/40.

#### WAVEFRONT-GUIDED INDICATIONS AND INTENDED USES (MIXED ASTIGMATISM):

The **VISX STAR S4 IR** Excimer Laser System with **VSS Refractive** Technology and **WaveScan WaveFront** System are approved to perform wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments for the reduction or elimination of naturally occurring mixed astigmatism when the magnitude of cylinder (from 1.0 to 5.0 D) is greater than the magnitude of sphere and the cylinder and sphere have opposite signs; and in patients 21 years of age or older with documented evidence of a change in manifest refraction of no more than 0.50 D (in both cylinder and sphere components) for at least one year prior to the date of preoperative examination. Note that the complete name for this ophthalmic laser is "**STAR S4 IR** Excimer Laser System" for wavefront-guided laser assisted *in-situ* keratomileusis (LASIK) treatments of naturally occurring mixed astigmatism when the magnitude of cylinder (from 1.0 to 5.0 D) is greater than the magnitude of sphere and the cylinder and sphere have opposite signs. An acceptable alternate version of this official name is "wavefront-guided LASIK for correction of mixed astigmatism."

Wavefront-guided LASIK for mixed astigmatism is an elective procedure with the alternatives including but not limited to eyeglasses, contact lenses, photorefractive keratectomy (PRK), conventional LASIK, and other refractive surgeries. Approval of the application is based on a clinical trial of 86 eyes. Of all eyes treated, 86 were evaluated for effectiveness with 100.0% accountability at 3 months, 80 eyes with 95.2% accountability at 6 months, 69 eyes with 86.3% accountability at 9 months, and 63 eyes with 94.0% accountability at 12 months. The studies found that of the 86 eyes eligible for the uncorrected visual acuity (UCVA) analysis of effectiveness at 3 months, 95.3% were corrected to 20/40 or better, 91.9% were corrected to 20/32 or better, and 61.6% were corrected to 20/20 or better without spectacles or contact lenses.

The study showed that of 86 astigmatic eyes, one eye temporarily lost 2 lines of best corrected vision that can be obtained with spectacles at 1 month and at 6 months, and none of the eyes had best spectacle corrected visual acuity (BSCVA) worse than 20/40.

#### CONTRAINDICATIONS:

Wavefront-guided LASIK is contraindicated in patients with collagen vascular, autoimmune or immunodeficiency disease, signs of keratoconus or abnormal corneal topography, patients taking isotretinoin (Accutane<sup>®</sup>) or amiodarone hydrochloride (Cordarone<sup>®</sup>) or are pregnant or nursing.

#### WARNINGS:

Wavefront-guided LASIK is not recommended in patients who have diabetes, a history of Herpes simplex or Herpes zoster keratitis, significant dry eye that is unresponsive to treatment, or severe allergies. For the treatment of low to moderate myopic astigmatism, lower uncorrected visual acuity may be anticipated in the treatment of higher degrees of myopia with and without astigmatism ( $\geq 5.0$  D MRSE).

#### PRECAUTIONS:

Long-term risks of wavefront-guided LASIK beyond 12 months have not been studied. The safety and effectiveness of wavefront-guided LASIK surgery have ONLY been established with an optical zone of 6 mm and an ablation zone of 8 mm for myopic treatments, and an ablation zone of 9 mm for hyperopic and mixed astigmatism treatments. The safety and effectiveness of the **STAR S4** Excimer Laser System have NOT been established for wavefront-guided surgery in patients with low to moderate myopic astigmatism: whose **WaveScan WaveFront** diameter is less than 6 mm; for treatments greater than -6 diopters of MRSE or with greater than 3 diopters of astigmatism and for retreatment with **CustomVue** LASIK. The safety and effectiveness of the **STAR S4** Excimer Laser System have NOT been established for wavefront-guided surgery in patients with high myopic astigmatism: whose **WaveScan WaveFront** diameter is less than 5 mm; for treatments greater than -11 diopters of MRSE or with greater than 3 diopters of astigmatism. The safety and effectiveness of the **STAR S4** Excimer Laser System have NOT been established for wavefront-guided surgery in patients with hyperopic astigmatism: whose **WaveScan WaveFront** diameter is less than 5 mm; for treatments greater than +3 diopters of MRSE or with greater than 2 diopters of astigmatism and for retreatment with **CustomVue** LASIK. The safety and effectiveness of the **STAR S4 IR** Excimer Laser System have NOT been established for wavefront-guided surgery in patients with mixed astigmatism: whose **WaveScan WaveFront** diameter is less than 5.00 mm; for treatments greater than 5.00 D or less than 1.00 D of astigmatism and for retreatment with **CustomVue** LASIK.

Although the **WaveScan WaveFront** System measures the refractive error and wavefront aberrations of the human eyes, including myopia, hyperopia, astigmatism, coma, spherical aberration, trefoil, and other higher-order aberrations through sixth order, in the clinical studies for low to moderate myopic astigmatism, hyperopic astigmatism and mixed astigmatism, the average higher-order aberration did not decrease after **CustomVue** treatment. In the clinical studies for high myopic astigmatism, the average higher-order aberration increased after **CustomVue** treatment.

It is possible, after wavefront-guided LASIK treatment, that patients will find it more difficult than usual to see in conditions such as very dim light, rain, snow, fog, or glare from bright lights at night. Visual performance possibly could be worsened by large pupil sizes or decentered pupils. Pupil size should be evaluated under mesopic illumination conditions.

#### ADVERSE EVENTS AND COMPLICATIONS (LOW TO MODERATE MYOPIC ASTIGMATISM):

The clinical trial showed that the following adverse events or complications occurred in at least 1% of the 351 eyes at any interval up to 6 months post-treatment: inflammation of the cornea under the flap (1.4%); double or ghost images (1.4%); and scratch on the surface of the eye (1.4%).

The following subjective symptoms frequency rated "often or always" were increased in the effectiveness cohort at 6 months post-treatment on 258 eyes compared with pre-treatment on 332 eyes: dryness (9% vs. 6%); fluctuation of vision (3% vs. 2%); glare (4% vs. 2%) and halos (7% vs. 5%).

#### ADVERSE EVENTS AND COMPLICATIONS (HIGH MYOPIC ASTIGMATISM):

The clinical trial showed that the following adverse events or complications occurred in at least 1% of the 184 eyes at one or more postoperative examinations up to 6 months post-treatment: cells growing under the flap (1.1%); scratch on the surface of the eye at 1 month or later (2.2%); swelling of the cornea between 1 week and 1 month postoperatively (2.7%) and double vision (or "ghost images") in the operative eye (6.0%).

The following subjective symptoms were reported as present "often or always" by a higher percentage of subjects 6 months after treatment than before treatment: dryness (10.8% vs. 9.3%); halos (21.6% vs. 15.4%); and ghosting or shadowing of images (2.8% vs. 1.1%).

#### ADVERSE EVENTS AND COMPLICATIONS (HYPEROPIC ASTIGMATISM):

The clinical trial showed that the following adverse events or complications occurred in at least 1% of the 144 eyes at any interval up to 6 months post-treatment: cells growing under the flap (2.1%); feeling of something in the eye (1.4%); double or ghost images (11.3%); and scratch on the surface of the eye (2.1%).

The following subjective symptoms rated "often or always" were increased in frequency in the effectiveness cohort at 6 months post-treatment on 131 eyes compared with pretreatment on 136 eyes: dryness (17% vs. 6%); blurry vision (10% vs. 7%); fluctuation of vision (14% vs. 6%); halos (10% vs. 5%); double or ghost images (7% vs. 3%).

#### ADVERSE EVENTS AND COMPLICATIONS (MIXED ASTIGMATISM):

The clinical trials showed that the following adverse events or complications occurred in at least 1% of the 86 eyes at one or more postoperative examinations up to 3 months post-treatment: miscreated flap (1.2%); cells growing under the flap (4.7%); and double vision (or "ghost images") in the operative eye (8.1%).

The following subjective symptoms were reported as present "often or always" by a higher percentage of subjects 3 months after treatment than before treatment: dryness (22% vs. 6%); halos (20% vs. 13%).

\*Accutane<sup>®</sup> is a registered trademark of Hoffmann-La Roche Inc.

\*Cordarone<sup>®</sup> is a registered trademark of Sanofi-Synthelabo, Inc.

Advanced  
CustomVue





## With CareCredit . . .

- ✓ Start care immediately
- ✓ Pay over time with low monthly payments
- ✓ For yourself and your family
- ✓ Two Types of Promotional Plans Available:

**No Interest if Paid in Full within 6, 12 or 18 Months †**  
On purchases with your CareCredit card. Not all promotional plans are available in all offices. Interest will be charged to your account from the purchase date if the promotional balance, including optional charges, is not paid in full within 6, 12 or 18 months or if you make a late payment. Minimum Monthly Payments Required.

or

**14.90% APR & Fixed Minimum Monthly Payments for 24, 36, 48 or 60 Months † †**  
On Purchases of \$1,000 or more (24, 36 or 48 months) or \$2,500 or more (60 months) with your CareCredit card. Accounts at Penalty APR ineligible for reduced APR. Fixed Minimum Monthly Payments Required. Penalty APR may apply if you make a late payment.

*(See page 11 for details)*

### Step 1 Please follow these guidelines when completing your application:

- ✓ **Please have available two forms of ID that can be verified: one primary ID and one secondary ID or two primary IDs. If using a co-applicant, the co-applicant must be present and also provide two forms of ID.** Acceptable primary ID are State issued driver's license (preferred), government issued ID, Non-Driver State issued ID, Passport, Military ID or Government issued Green/Resident Alien card. Acceptable secondary IDs are Visa, MasterCard, American Express, Discover, department store or an oil company credit card with an expiration date.
- ✓ **Please include all forms of income from all full and part-time jobs, bonuses, commissions, and investments.** You need only include child support, alimony, or separate maintenance income if you wish this income to be considered in your application.
- ✓ **Please note that you must reside in the United States and be 18 years or older to apply.**

### Step 2 Please complete the rest of the application on the reverse side



A credit service of GE Money Bank

APPLICATION AND CREDIT CARD AGREEMENT

For Providers: (800) 859-9975

For Patients/Clients: (800) 365-8295

Submit by internet: CARECREDIT.COM

ESTIMATED FEE \$ Office Merchant # Pre-Approval Offer
Photo ID verified (initial): Applicant 1st ID Type / Number Issuance State Exp. Date Applicant 2nd ID Type / Issuer Exp. Date
Provided by GE Money Bank: Account # Authorization # or Key # Approved Credit Limit

1. APPLICANT INFORMATION: Please tell us about yourself. For WI residents: If you are applying for individual credit or joint credit with someone who is not your spouse, combine your and your spouse's financial information on the application form.

Name (First-Middle-Last) Please Print Date of Birth Social Security Number Home Phone Number
Mailing Address\* Apt.# City State Zip Cell/Other Phone Number
Housing Information Nearest Relative Phone Number Alimony, child support or separate maintenance income need not be disclosed unless relied upon for credit. Monthly Net Income From All Sources Employer's Phone Number
E-Mail Address (optional) By providing an e-mail address, I consent to receive e-mail confirmation of my Application, communications about my Account and periodic offers and updates from GE Money Bank and CareCredit LLC.

2. CO-APPLICANT INFORMATION: (COMPLETE ONLY IF CO-APPLICANT REQUESTING A CARECREDIT CREDIT CARD)

Name (First-Middle-Last) Please Print Date of Birth Social Security Number Home Phone Number
Mailing Address\* Apt.# City State Zip Cell/Other Phone Number
Housing Information Nearest Relative Phone Number Alimony, child support or separate maintenance income need not be disclosed unless relied upon for credit. Monthly Net Income From All Sources Employer's Phone Number
Co-Applicant ID Type / Number Issuance State Exp. Date Co-Applicant 2nd ID Type / Issuer Exp. Date
E-Mail Address (optional) By providing an e-mail address, I consent to receive e-mail confirmation of my Application, communications about my Account and periodic offers and updates from GE Money Bank and CareCredit LLC.

3. APPLICANT and CO-APPLICANT: We need your signature(s) below

I am providing the information in this application to GE Money Bank ("GEMB"), to CareCredit LLC, to participating professionals ("Participating Professionals") that accept the CareCredit Credit Card ("Card") and to program sponsors, and asking GEMB to issue me a Card. By applying for this account, I authorize and agree that:

- GEMB may furnish this and other information about me (even if my application is denied) and my account to CareCredit LLC and to Participating Professionals and program sponsors (and their respective affiliates) to create and update their records, and to provide me with service and special offers.
GEMB may make inquiries it considers necessary (including requesting reports from consumer reporting agencies and other sources) in evaluating my application, and for purposes of reviewing, maintaining or collecting my account.
If my application is approved, the GEMB Credit Card Agreement ("Agreement"), a copy of which is attached, will be sent to me and will govern my account.
Among other things, the Agreement: (1) INCLUDES A DISPUTE AND CLAIM RESOLUTION (INCLUDING ARBITRATION) PROVISION THAT MAY LIMIT MY RIGHTS UNLESS I REJECT THAT PROVISION UNDER THE AGREEMENT'S INSTRUCTIONS; and (2) makes each applicant responsible for paying the entire amount of credit extended; and (3) grants GEMB a security interest in the goods purchased on the account as permitted by law.
I consent to GEMB and any other owner or servicer of my account contacting me about my account, including using any contact information or cell phone numbers I provide (whether now or in the future), and I consent to the use of any automatic telephone dialing system and/or an artificial or prerecorded voice when contacting me, even if I am charged for the call under my phone plan.
This application and the Agreement are governed by federal law and Utah law (to the extent that state law applies).

Federal law requires GE Money Bank to obtain, verify and record information that identifies applicants when opening an account. GE Money Bank will use applicants' name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request that you open the type of account for which I was pre-approved. I have read the Prescreen Disclosures, Key Credit Terms and Agreement on the next pages and have been provided my credit line applicable to the account. GEMB reserves the right to refuse to open an account in my name if GEMB determines that I no longer meet GEMB's credit criteria or if I do not meet GEMB's debt to income requirements.

Signature of Applicant Signature of Co-Applicant (If Applicable)
X Date X Date
(Please Do Not Print) (Please Do Not Print)

<b>PATIENT NAME</b>			<b>HOME PHONE#</b> (    )		<b>ALTERNATE PHONE#</b> Work / Cell / Other (    )	
<b>E-MAIL ADDRESS</b>						
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>
<b>SEX</b>	<b>AGE</b>	<b>BIRTH DATE</b>		<b>MARITAL STATUS</b> S    M    D    W		<b>SOCIAL SECURITY NUMBER</b>
<b>EMPLOYER</b>				<b>OCCUPATION</b>		
<b>SPOUSE NAME</b>			<b>BIRTHDATE</b>		<b>SPOUSE'S EMPLOYER</b>	
<b>NEXT OF KIN NAME/PHONE NUMBER</b>						
<b>MEDICAL INSURANCE</b>						
Primary		Secondary			Tertiary	
<b>VISION INSURANCE</b>						
Primary				Secondary		
<b>REFERRED BY</b>					<b>PHONE</b> (    )	
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>
<b>PRIMARY CARE PHYSICIAN</b>					<b>PHONE</b> (    )	
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>
<b>PHARMACY NAME</b>			<b>PHONE</b>			<b>CITY</b>
<b>PHARMACY ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>

DATE: \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_

Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_



## **DIRECTIONS TO OUR OFFICES**

**Call (734)283-0500 if you have any questions**

### **20500 EUREKA ROAD, SUITE 200, TAYLOR, MI 48180**

Located in a three story gray brick building between I-75 & Allen Rd., across from Denny's and Bob Evans. Ample free parking is available behind the building.

#### **From Telegraph (US24)**

Telegraph to Eureka Road; travel east for approximately 1.5 miles.

#### **From the North (Detroit, Troy) on I-75**

I-75 South to the Eureka Road Exit (#36). Turn left onto Eureka Road; travel east for about 1/3 mile.

#### **From the South (Monroe, Toledo) on I-75**

I-75 North to the Eureka Road Exit (#36). Turn right onto Eureka Road; travel east for about 1/3 mile.

#### **From I-275**

I-275 to the Eureka Road Exit (#15); travel east on Eureka Road for approximately 8 miles.

#### **From Belleville, Ann Arbor, and further west on I-94**

I-94 East to I-275 South, then follow the I-275 directions above.

### **113 E. LONG LAKE ROAD, TROY, MI 48085**

Located in the Sunset Plaza (along with Kroger and CVS), on the northeast corner of the E. Long Lake Road/Livernois intersection.

#### **From I-75**

We are about 1/4 mile east of I-75. Take the Big Beaver Road Exit (#69) and go east to Livernois. Travel north on Livernois to E. Long Lake Road.

#### **From Canton, Livonia, and Northville areas on I-275**

I-275 North to 696 East to I-75 North, then follow either set of I-75 directions above.

#### **From Belleville, Ann Arbor, and further west on I-94**

I-94 East to I-75 North, then follow either set of I-75 directions above.

**HEALTH HISTORY**

**PATIENT NAME** \_\_\_\_\_

**DATE:** \_\_\_\_\_

- Yes No  
  Diabetes \_\_\_\_\_ # of yrs. \_\_\_\_\_  
  High Blood Pressure \_\_\_\_\_ # of yrs. \_\_\_\_\_  
  Heart Disease \_\_\_\_\_  
  Kidney Disease \_\_\_\_\_  
  Neurological Disease \_\_\_\_\_  
  Carotid Artery Disease \_\_\_\_\_  
  Stroke \_\_\_\_\_  
  Cancer- Type \_\_\_\_\_ Date \_\_\_\_\_  
  Anxiety disorder or depression? \_\_\_\_\_  
  Gastrointestinal Disease-Type \_\_\_\_\_  
  Lung Disease-Type \_\_\_\_\_  
  Thyroid disease \_\_\_\_\_

- Yes No  
  Arthritis (osteo/rheumatoid) \_\_\_\_\_  
  Autoimmune Disease  Lupus  HIV/Aids  Crohn's  Fibromyalgia  
  Chron. Fatigue Syn.  MS  Other \_\_\_\_\_  
  Migraines \_\_\_\_\_  
  Head or Spinal Injuries \_\_\_\_\_  
  Seizure, Convulsions, or Fainting \_\_\_\_\_  
  (Women) Are You Pregnant or Nursing? \_\_\_\_\_  
  Permanent Defect from Illness, Disease or Injury? \_\_\_\_\_  
  Do You Live Alone? \_\_\_\_\_  
  Do You Smoke? Cig./Pks. Per Day \_\_\_\_\_ Week \_\_\_\_\_  
  Do You Drink? # per Day/Week//Month \_\_\_\_\_  
**Other:** \_\_\_\_\_

**Please List ALL MEDICATIONS You Are Currently Taking:**  Continued on back of sheet

**EYE MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please List All Medications You Are **ALLERGIC** To:  **NO KNOWN ALLERGIES**

**YOUR OCULAR HISTORY** (Have YOU been diagnosed with any of the following in the past?)

- |   |   |  |   |
|---|---|--|---|
| Yes No  | <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ | Yes No   | <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes/"Lazy" Eye _____ |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____        |   | <input type="checkbox"/> <input type="checkbox"/> Iritis _____               |   |
| <input type="checkbox"/> <input type="checkbox"/> Retinal Disease _____ |   | <input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____      |   |
| <input type="checkbox"/> <input type="checkbox"/> Injury _____          |   | <input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders: _____ |   |

**FAMILY HISTORY** Has anyone in your family (**BLOOD RELATIVE**) had any of the following?

**NOTE RELATION TO PATIENT: F-Father M-Mother S-Sister B-Brother GF-Grandfather GM-Grandmother U-Uncle A-Aunt**

- |   |  |   |  |  |   |  |  |
|---|--|---|--|--|---|--|--|
| Yes No  | <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____ | Yes No  | <input type="checkbox"/> <input type="checkbox"/> Macular Degen. _____ | Yes No   | <input type="checkbox"/> <input type="checkbox"/> Retinal Detach. _____ | Yes No   | <input type="checkbox"/> <input type="checkbox"/> Other Eye Problems _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ |  | <input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____ |  | <input type="checkbox"/> <input type="checkbox"/> Diabetes _____ |   | <input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____ |  |

**YOUR SURGICAL HISTORY** (Please include date and type)

Continued on back of sheet

**DO NOT WRITE IN THIS SPACE**

No Ocular LASER/surgery

Cataract Surgery (Date of Surgery) Right Eye \_\_\_\_\_ YAG caps \_\_\_\_\_ Left Eye \_\_\_\_\_ YAG caps \_\_\_\_\_  
 Other Eye Surgery and/or Laser (Date of Surgery) Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Date Reviewed \_\_\_\_\_ Tech Initial (Please Print) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date Updated - Tech Initial \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ U-forms

**HEALTH HISTORY**

**REVIEW OF SYSTEMS: Do you have any of the following symptoms now?**

If NO, Please check box. If YES, please circle all words that apply.

NO **General:** fever, chills, unexplained weight loss/gain, night sweat, scalp tenderness, fatigue

NO **Ears, Nose, Throat:** ear pain, facial pain, chronic cough, dry mouth, sneezing, hearing loss

NO **Eye:** pain, blurred vision, double vision, redness, burning, itching, discharge, light sensitivity, flashing lights, floaters

NO **Heart:** chest pain, rapid heart beat, high blood pressure

NO **Respiratory:** shortness of breath, difficulty breathing, discolored sputum, wheezing, congestion

NO **Digestive:** constipation, nausea, vomiting, blood in stools, black tarry stools, diarrhea, upset stomach

NO **Genital, Kidney:** increased urinary frequency, pain with urination, impotence

NO **Muscle:** pain in joints, pain in muscles, stiffness, swelling, cramps

NO **Skin:** rash, bruising, pimples, warts, growths, redness, itching, hives, swelling

NO **Neuro:** dizziness, weakness, numbness, tingling, trouble speaking, bowel/bladder dysfunction, loss of balance, headache

NO **Psychiatric:** Anxiety, depression, insomnia

If you answered yes to any of the above questions and are not currently receiving care for these symptoms, report them to your family physician as soon as possible.

**When did you have your last complete physical exam?**

Approximate Date: \_\_\_\_\_ Family Doctor's name: \_\_\_\_\_

List of Medications (Cont'd)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Surgical History (Cont'd)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**LASIK EXAM INFORMATION**

1. Your consultation visit with the ophthalmologist will last approximately 2 hours.
2. To perform a complete eye examination, your eyes will be dilated. This causes light sensitivity and blurry near vision and may last for 24 hours.
3. If you are concerned about driving while dilated, please have a driver accompany you.
4. Bring your current eyeglasses (or prescription) with you, as well as sunglasses—we can provide sunglasses if needed.
6. LASIK fees vary based on your level of correction and will be determined during your appointment.

**CONTACT LENS PATIENTS – IMPORTANT!!**

<b>If Your Contacts Are:</b>	
<b>Hard Contacts/Rigid/Gas Permeable</b>	<b>Do not wear contacts for 3 full weeks prior to exam</b>
<b>Soft Extended Wear – If you sleep in your contacts for up to a week at a time</b>	<b>Do not wear contacts for 2 full weeks prior to exam</b>
<b>Soft Extended Wear – If you sleep in them for more than 2 weeks at a time</b>	<b>Do not wear contacts for 3 full weeks prior to exam</b>
<b>Soft Daily Wear – If you never sleep in contacts</b>	<b>Do not wear contacts for 2 weeks prior to exam</b>

***Enclosed in this packet you will also find:***

- \*Why should you have LASIK at the Castleman Eye Center?**
- \*Financing information-Care Credit**
- \*Health History & Demographic forms (please complete and bring to your appointment)**
- \*Directions to our offices**
- \*CustomVue LASIK brochure**

1-800-403-0060

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