Dear patient,

I would like to take a moment to personally welcome you to Conestoga Eye.
At Conestoga Eye *we see you*, and we are excited that you will be visiting us soon.

It is our mission to provide unparalleled eye care for adults and children in a caring environment. We offer a full range of services for infants to adults and from medical exams to routine exams to cosmetic procedures. We thank you for selecting us for your family's eye care needs.

Before your appointment please take a few minutes to complete the new patient forms. In order to help minimize our carbon footprint, we ask you to complete these forms electronically or on our patient portal. If you prefer to fill out the forms on paper, they can be downloaded from our website, emailed, or postal mailed to you. You may fax, email, or mail them back to us, or bring them with you to your visit.

If you wish to fill out the forms when you arrive, please arrive 20 minutes before your appointment.

For your appointment, please remember:

- Bring your medical insurance and vision insurance cards.
- Most insurance companies require a copayment for office visits. Please check to see what your insurance requires for a specialist and be prepared to pay this as you check in. We accept cash, check, Visa, Mastercard, Discover, and American Express.
- Some insurance providers require you to receive a referral from your family doctor. Please check with your insurance company and ask your family doctor to send this to us if needed.
- Bring a list of your medications (including vitamins and supplements) to your appointment or enter this information into your chart through your patient portal.
- Please give us at least 24 hours notice if you are unable to keep your appointment so we can then give your appointment slot to someone who urgently needs care.
- Bring your eyeglasses and contact lenses.
- Bring along any previous records that may be helpful.

A new patient seeing an eye doctor usually requires dilation of the eyes to do a full exam. This makes for a longer doctor's appointment (1-2 hours). The eye drops will cause you to be light sensitive for the rest of the day, often blurring your vision for near, and sometimes for far, distance. Please consider bringing sunglasses and a driver if your vision is too blurry to drive.

Our office offers free wifi! Please bring your cell phone, tablet, or laptop to occupy your time while you wait for your eyes to dilate, but please be courteous of our staff and other patients and keep your devices silenced.

If you have any questions or concerns or need to change your appointment date, please contact our office. Thank you for choosing Conestoga Eye, we look forward to serving you.

Sincerely,

David I. Silbert MD, FAAP

Patient Name ____ Patient Birth Date ______/_____/______

We ask the following questions for information gathering purposes only.
The answers have no bearing on patient care.
It helps us in our pursuit to provide better services to all patients.

1. Do you consider yourself to be Hispanic or Latino (see definition below) **?** **YES** **NO**

Hispanic or Latino: *A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".*

2. What race do you consider yourself to be? (If more than one race, select all that apply.)

- ○ **American Indian or Alaska Native** A person having origins in any of the original peoples of North, Central, or South America, and who maintain tribal affiliations or community attachment.
- ○ **Asian** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, or the Philippine Islands.
- ○ **Black or African American** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American".
- ○ **Native Hawaiian or other Pacific Islander** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ○ **White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ○ **Uncertain**

Patient Registration Form

Patient Information

First Name	Last Name	MI	Birth Date
Address	City	State	Zip
Home Phone	Cell Phone	Age	Sex M F	SSN
Email Address	Yes! Contact me by: (Select all that apply)	Email Phone Text	
Occupation	Employer	Employer Phone	
Employer Address	City	State	Zip
Marital Status: Single Married Widowed Divorced	Spouse's Name		
Spouse's Birth Date	Spouse's SSN	Spouse's Employer	Spouse's Phone Number

Please complete if patient is under age 18 or a college student

Parent 1: First Name	Parent 1: Last Name	Relationship F M G	Parent 1: Birth Date	
Parent 1: Home Phone	Parent 1: Cell Phone	Parent 1: Email Address		
Parent 1: Address	City	State	Zip	Parent 1: SSN
Parent 1: Employer	Parent 1: Employer Phone	Yes! Contact me by: (Select all that apply) Email Phone Text		
Parent 2: First Name	Parent 2: Last Name	Relationship F M G	Parent 2: Birth Date	
Parent 2: Home Phone	Parent 2: Cell Phone	Parent 2: Email Address		
Parent 2: Address	City	State	Zip	Parent 2: SSN
Parent 2: Employer	Parent 2: Employer Phone	Yes! Contact me by: (Select all that apply) Email Phone Text		

Referral Information

Name of Family Physician		Name of Physician's Practice
Name of Optometrist		Name of Optometrist's Practice
Name of Preferred Pharmacy	Pharmacy Phone Number ( ) -	Pharmacy Addresss
Were you referred here today by any of your physicians? If so, whom?		
How did you hear about our practice?		

ADULT Medical Information Form

Patient Name ____ Patient Birth Date ______/_____/______

What do you wear? Glasses Contact Lenses

Please circle the yes if you have one of the conditions listed below.

Medical Problems

Condition	Please Circle	Date	Condition	Please Circle	Date
Alzheimer's	Yes		Lupus	Yes	
Arthritis	Yes		Migraine Headaches	Yes	
Asthma/COPD/Bronchitis	Yes		High Cholesterol	Yes	
Cancer: Type __________	Yes		Sarcoidosis	Yes	
Diabetes: Type ________	Yes		Seizures	Yes	
High Blood Pressure	Yes		Stroke	Yes	
Hepatitis/Jaundice	Yes		Syphilis/Gonorrhea	Yes	
Heart Disease	Yes		Thyroids Disease	Yes	
Head Injury	Yes		Tuberculosis	Yes	
HIV Positive/AIDS	Yes		*Other Medical Problems (Please List)*		
Kidney Disease	Yes				

Surgical History

Have you had **general** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Social History

Are you pregnant?	Yes
Do you smoke?	Yes
Do you drink alcohol?	Yes
Do you drink caffeine?	Yes
Do you use illegal drugs?	Yes

Family Medical Problems

Family members have	Please Circle	Relative
Glaucoma	Yes	
Macular Degeneration	Yes	
Diabetes	Yes	
Retinal Detachment	Yes	
Cataracts	Yes	
Amblyopia/Strabismus	Yes	
Other (list)		

Medications (Please List)

Name	Dosage

Are you allergic to any medications, iodine, latex, or anesthesia? Yes No If **yes**, please list below:

CONESTOGA EYE

PEDIATRIC Medical Information Form

Patient Name ____ Patient Birth Date _______/______/_______

What does your child wear? Glasses Contact Lenses

Please circle the yes if following apply to your child and the date it first occurred.

Medical Problems

Birth Information	Please Answer	
Gestational Age		
Delivery Type		
Emergency Delivery	Yes No	
Birth Weight		
Birth Abnormalities		
Complications		
Developmental Delays	None	Congnative
	Delayed Motor Skills	Intellectual
	Learning	Motor
	Reading	Speech

Condition	Please Circle	Date
Arthritis	Yes	
Asthma/COPD/Bronchitis	Yes	
Cancer: Type ______	Yes	
Diabetes: Type _____	Yes	
Hepatitis/Jaundice	Yes	
Head Injury	Yes	
Genetic Disorder	Yes	
Migraine Headache	Yes	
Seizures	Yes	
Stroke	Yes	
Thyroid Disease	Yes	

Other Medical Problems (Please List)

Surgical History

Has your child had **general** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Has your child had **eye** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Medications (Please List)

Name	Dosage

Is your child allergic to any medications, iodine, latex, or anesthesia? Yes No
If **yes**, please list below:

Family Medical Problems

Family members have	Please Circle	Relative
Glaucoma	Yes	
Macular Degeneration	Yes	
Diabetes	Yes	
Retinal Detachment	Yes	
Cataracts	Yes	
Amblyopia/Strabismus	Yes	
Other (list)		

Social History

Is your child pregnant?	Yes
Does your child smoke?	Yes
Does your child drink alcohol?	Yes
Does your child drink caffeine?	Yes
Does your child use illegal drugs?	Yes

CONESTOGA EYE

Medical Review of Systems

Patient Name ______________________________ Patient Birth Date ______/______/______

Do you currently have any problems in the following areas?

Please circle **YES** if you have one of the issues/conditions listed below.

CONSTITUTIONAL	
Fever	Yes
Fatigue	Yes
Weight Loss	Yes
Weight Gain	Yes
EYES	
Loss of Vision	Yes
Loss of Side Vision	Yes
Distorted Vision or Halos	Yes
Fluctuating Vision	Yes
Flashes	Yes
Floaters	Yes
Eye Pain or Soreness	Yes
Light Sensitivity	Yes
Double Vision	Yes
Crossing or Drifting of Eyes	Yes
Redness	Yes
Discharge	Yes
Foreign Body Sensation	Yes
Sandy or Gritty Feeling	Yes
Dryness	Yes
Itching	Yes
Burning	Yes
Excess Tearing/Watering	Yes
Glare	Yes
Styes	Yes
Other	
EARS, NOSE, MOUTH, & THROAT	
Hearing Difficulty	Yes
Ringing	Yes
Vertigo	Yes
Sinus Congestion	Yes
Runny Nose	Yes
Post-Nasal Drip	Yes
Nosebleeds	Yes
Dry Throat/Mouth	Yes
Hoarseness	Yes
Jaw Claudication	Yes

CARDIOVASCULAR		
Chest Pain		Yes
Palpitations		Yes
Other		
RESPIRATORY		
Cough		Yes
Shortness of Breath		Yes
Wheezing		Yes
GASTROINTESTINAL		
Swallowing Difficulty		Yes
Vomiting		Yes
Heartburn		Yes
Diarrhea		Yes
Constipation		Yes
Nausea		Yes
GENITO-URINARY		
Urinary Frequency		Yes
Urinary Pain or Blood		Yes
MALES	Discharge	Yes
	Lesions or Masses	Yes
FEMALES	Currently Pregnant	Yes
	Breast Masses	Yes
	Breast Discharge	Yes
	Vaginal Bleeding/ Discharge	Yes
MUSCULOSKELETAL		
Joint Pain		Yes
Swelling		Yes
Redness		Yes
Muscle Pain		Yes
Muscle Cramps		Yes
SKIN		
Rashes or Color Changes		Yes
Itching or Dryness		Yes
Hair or Nail Changes		Yes

NEUROLOGICAL	
Headaches	Yes
Numbness	Yes
Tingling	Yes
Weakness	Yes
Paralysis	Yes
Fainting	Yes
Blackouts	Yes
Slurred Speech	Yes
PSYCHIATRIC	
Anxiety	Yes
Depression	Yes
Other (list)	
ENDOCRINE	
Heat Intolerance	Yes
Cold Intolerance	Yes
Excessive Thirst	Yes
Excessive Hunger	Yes
HEMATOLOGIAL	
Easy Bruising	Yes
Easy Bleeding	Yes
Blood Transfusions	Yes
Swollen Lymph Nodes	Yes
ALLERGY	
Seasonal Allergies	Yes
ADDITIONAL NOTES/COMMENTS	

Summary of Patient Financial Policy
Consent to Treatment
Consent to Dilate

Thank you for choosing Conestoga Eye for your complete eye care.

Dr. Silbert and the Conestoga Eye team value the trust and responsibility you place in us, and we look forward to establishing a long-term relationship with you and your family.

Consent to Treatment & Release of Medical Information

By Signing the below, I consent to examination and treatment with Conestoga Eye PC. I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services and its agents to release any information needed to determine these benefits payable for related services. If Medicare denies payment, I agree to be personally and full responsible for payment.

Consent to Dilate

Dilating drops are used to enlarge the pupils of the eyes which allows the ophthalmologist or optometrist to view the health of your eye. Dilating drops are also used to for special testing, such as cycloplegic refractions.

The side affects of dilating drops can include blurry vision, light sensitivity, and trouble reading. These symptoms usually wear off in 4-48 hours depending on the strength of the drops and the individual patient. The drops can cause driving to be difficult. If you are not sure how the drops will affect you we suggest you bring a driver to take you home after your appointment.

On rare occasion patients may have a more severe adverse reaction to the drops, such as acute angle-closure glaucoma. This is rare and can be treated with immediate medical attention. Some patients may also experience facial flushing or change in mood.

I authorize Conestoga Eye (the doctor or assistant as may be designated by the doctor) to administer the dilating drops. The drops are necessary for a full comprehensive eye exam.

Financial Policy Statement

Registration and Financial Information

To process a claim on your behalf, it is important for you to provide your complete health care insurance coverage information, your employment information, and your guarantor (another individual responsible) information. It is our policy to update and/or confirm the accuracy of this information at each office visit.

It is also your responsibility to inform us in a timely manner of any changes with your health care insurance. If an insurance company denies payment of a claim for incomplete or inaccurate information, it will then be your responsibility to make payment in full. If your insurance requires a referral form or prior authorization, it is your responsibility to obtain this form from your primary care physician prior to your appointment.

Payment at the Time of Service

Your insurance company will be billed for services rendered; however, please be prepared to pay any co-payments and non-covered services, including deductible charges, at the time of your visit. If you cannot pay your co-payment, we will reschedule your appointment to later in the day or to another day. All previous outstanding patient balances will be collected at the beginning of your visit unless other arrangements have been made.

Credit Cards

Conestoga Eye accepts Visa, MasterCard, American Express, and Discover. We offer the option to authorize payment of balances due after insurance payment is received. *Please contact our office in advance to request this option.* You may also pay your bill online at conestogaeye.com.

Self-Pay Patients

We offer a reasonable discount for our cash-paying patients. Cash-paying patients are asked to speak to our office at 717-541-9700 for an estimate of what will be due at the time of service.

Payment Plans

Please contact the office at 717-541-9700 to discuss establishing a payment plan for large balances. The office will arrange for monthly payments or authorized automatic credit card transactions until the balance is paid in full.

Insurances, Health Plans, and Medical Benefit Programs

Conestoga Eye participates with many insurance companies. Contact your insurance company to inquire if we participate with them. A customer service number can be found on your insurance card. If we are non-participating, you can find out if you are authorized to receive care from an "out of network provider" and if any additional costs will be incurred. For a full list of insurances accepted by Conestoga Eye, visit conestogaeye.com.

Additional Charges and Fees

- There will be a $25 fee assessment for all checks returned unpaid by your bank.
- Completion of disability forms and employer forms are not a medical service and are not paid by insurance companies. There is a $25 fee for completion of these forms.
- There is a fee for copying medical records based on guidelines established by the Commonwealth of PA.
- A legal release is required.
- If your account is not paid within 60 days, the account will be turned over to a collection agency.
- Collection and/or legal fees will be added to the balance of your account.

Lab/Hospital Charges

Any service provided by a lab, outpatient surgery center, or hospital is a contract between you and that lab, surgery center, or hospital. Any billing dispute is not the responsibility of our practice. It is your responsibility to know which procedures or services your insurance company will or will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

We see you.

Thank you for choosing Conestoga Eye for your healthcare needs. Our mission is to provide you and your family with unparalleled eye care in a caring environment. If you have any questions about this information, please feel free to contact us by phone at (717) 541-9700 or by email with eyes@conestogaeye.com.

Patient (or legal guardian) Signature ______________________________________ **Today's Date** ____________