Conway Eye Care
1319 White Mountain Hwy
North Conway, NH 03860-5155
Ph: (603) 356-3000 F: (603) 356-4101
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Coos Eye Care
820 Main St
Berlin, NH 03570-2431
Ph: (603) 752-3510 F: (603) 752-6887
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Welcome to our offices! We look forward to caring for your eyes and your vision! Your appointment will be scheduled after you have completed and returned the attached forms. **Please review all of the important information below to prepare for your visit and arrive ten (10) minutes prior to your appointment time.**

Appointment Confirmation

- Prior to your appointment, we will contact you by text or phone to confirm your appointment. Please ensure that you are able to receive text messages and/or voicemails. Please reply to confirm when you receive your reminder.
- As a courtesy to our office and other patients that are waiting for appointments, please allow 24 hour notice to cancel or reschedule any appointment. **Failure to provide 24 hour notice may result in a delay in rescheduling your visit, as well as a missed appointment fee of $50.**
- Please be aware that if you are more than ten (10) minutes late, your appointment will need to be rescheduled in fairness to those patients who arrive on time.
- If you would like to visit our optical department on the day of your visit, please notify our office so we can plan accordingly. Due to staffing, our optical is available by appointment only.

What to Bring

In order to provide you with the best service and complete care visit, **please bring the following** to your appointment:

- **All attached paperwork**: Please fill out the attached information in full, including Records Release for your last eye care provider. For greatest efficiency, we ask all new patients to return these forms PRIOR to the day of your visit.
- **Eyeglasses:** Please bring any and all glasses that you currently use, including new and old prescription glasses, sunglasses, over the counter magnifiers, and even broken glasses.
- **Contact Lenses:** Please *wear* your current contact lenses to the appointment and *bring* the written contact lenses prescription from your previous doctor.
- **Medications:** Please bring a list of all medications that you are taking at this time.
- **Your Insurance Card(s):** If your visit is being billed to insurance, your insurance card must be presented at every visit. Missing/outdated insurance information prevents billing to insurance and causes the visit to be private pay.
- **Mask or Face Coverings** are required at all times in our office, as we are a medical facility caring for many high risk individuals. Please notify our office prior to your visit if you have any new symptoms of, or any recent exposure to, potentially contagious illness (including COVID, cold, flu, etc).

Insurance Coverage

Depending on your insurance plan, you may or may not have coverage for a “routine eye exam” (wellness exam without any medical conditions). Most medical insurances provide coverage for medical conditions such as dry eye, diabetes, cataracts, etc. Please contact your insurance carrier directly to learn what your specific policy provides.

- We do not know what your specific plan covers so you are responsible for understanding your individual policy (including benefits, coinsurances, copays, and deductibles) prior to arrival.
- **Our offices are in-network with the following** (among others): Medicare Part B, some but NOT ALL Medicare Advantage plans, Blue Cross Blue Shield, Harvard Pilgrim, United Health Care, Cigna, Aetna, NH Healthy Families.
- **Our offices are NOT in-network with the following:** All vision plans (including VSP, EyeMed, Davis Vision, Spectera Vision, Superior Vision, Blue View Vision, Cigna Vision, UHC Vision, Aetna Vision), Ambetter, Wellsense, Amerihealth, Humana, MaineCare.

Thank you and we look forward to your visit!
Conway Eye Care and Coos Eye Care

PATIENT REGISTRATION

Today's Date:________________________

Full Name: ____________________________________ **Preferred Name**: _______________

DOB: _________ **Sex (at birth):**_________ **Gender:** _________

MAILING Address:____

Cell Phone: ________________ **Home Phone:** ______________ **Work Phone:** ______________

Which number should we call first? (Circle): Cell Home Work
Consent for appointment reminders via text? (Circle): Yes No

Email: ____

Parent/Guardian:__________________________ **Relationship**:_______________________

Emergency Contact Decline to provide Emergency Contact: ________ (initial)

Name:__________________________ Relationship:________________ Phone: ___________

Do we have permission to discuss your medical care with this person? Yes / No
Do we have permission to contact this person if we are unable to reach you? Yes / No

Employer / Occupation: ____

Insurance Carrier: ___________________________________ **Policy/ID Number** ________________

Secondary Insurance (if any): ________________________ **Policy/ID Number** ________________

Primary Care Provider/Family Doctor:______________________ **Town/City**__________________

Preferred Pharmacy:_____________________________________ **Town/City**________________

Preferred Language:____________

Race: (Please circle) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Other Decline to answer

Ethnicity: (Please circle) Hispanic or Latino Not Hispanic or Latino Decline to answer

PATIENT CONSENTS

Patient Name:______________________________ Date of Birth:__________Today's Date:_________

For patients under 18 or any patient incapable of providing informed consent to medical treatment:
By my signature here, I certify that I am authorized by law to provide consent on behalf of the Patient.
Parent/Guardian Name (please print): **________________________________Relationship:____________**
Patient (or Guardian) Signature:____________________________________ Date: _____________

Financial Acknowledgement and Missed Appointment Fee:

I accept responsibility for providing correct and complete insurance information at the time of service and I accept responsibility for all charges not covered by my insurance. I understand that any attempt to verify insurance benefits are not a guarantee of coverage. I understand that accounts over 30 days past due will incur finance charges and accounts over 90 days past due will be turned over to a collection agency and will incur collection fees. I understand that a $50 fee will be charged for missed appointments and appointments canceled with less than 24 hours notice.
Patient (or Guardian) Signature:________________________________ Date: _____________

HIPAA Policy Acknowledgement:

I acknowledge that I have been offered/provided a copy of the HIPAA Patient Authorization to Disclose Health Care Information for Conway Eye Care / Coos Eye Care. I fully understand and I give my consent as detailed in that authorization, to disclose my health care information to health care providers involved in my care, to my health insurance carrier, and to any individuals that I have specifically identified.
Patient (or Guardian) Signature:________________________________ Date: _____________

Consent for Treatment:

I do hereby consent to examination at Conway Eye Care / Coos Eye Care and to the rendering of such care and medical treatment as may be deemed necessary and/or appropriate by the physicians and other clinical personnel of the practice, including dilation. I give my consent to use electronic prescribing in order to send/refill prescriptions to my preferred pharmacy and verify medication lists as available. I also consent to telehealth virtual care services when I request them.
Patient (or Guardian) Signature:________________________________ Date: _____________

Pupil Dilation Consent:

I have read the information provided regarding pupil dilation and understand that without dilation, detection of internal ocular disease is limited. Please select one and initial:
_________ YES, I consent to pupil dilation today for the most complete exam.
_________ YES, I consent to pupil dilation today, but only if necessary.
_________ NO, I do not consent to pupil dilation today.

Retinal Screening Consent:

I have read the information provided regarding optional retinal screening technology, which my doctor recommends to enhance assessment of my ocular health. Please select one and initial:
_________ I elect to have the $40 Optomap screening photo (Conway location only).
_________ I elect to have the $50 OCT screening scan (Berlin location only).
_________ I would like to speak to the doctor for more information.
_________ I decline these services, thus limiting the doctor's ability to optimally assess my ocular health.

PATIENT HEALTH INFORMATION

Patient Name:_________________________ **Date of Birth:**__________**Today's Date:**_________

Medication Allergies: ____

Other Allergies (including LATEX): ____

Please provide a copy of your medication list or write below:

Medication Name (Include Vitamins and Over the Counter)	Reason for Use

Do you use any of the following? (Please circle) Oxygen CPAP Machine None of these

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Review of Eye History: Do you currently have or have you ever had the following:

	Yes	No		Yes	No
Glaucoma			Lazy Eye		
Cataract			Retinal Disease		
Macular Disease			Injury		
Eye Surgery			Dry Eyes		
LASIK/RK/PRK			Allergy		
Infection			Other		

Alcohol Use: (Circle one) Yes, amount (per week):_____________ Yes, Socially:__________ None
Tobacco Use: (Circle one) Yes, amount + type:_________________ Former use, Quit date:_______ None

Family Eye History (Circle all that apply to indicate relationship):

Macular Degeneration: Unknown None Father Mother Brother Sister Son Daughter Other:_______
Cataract: Unknown None Father Mother Brother Sister Son Daughter Other:_________
Glaucoma: Unknown None Father Mother Brother Sister Son Daughter Other:_________

Family Health History (Circle all that apply to indicate relationship):

Cancer: Unknown None Father Mother Brother Sister Son Daughter Other:_________
Diabetes: Unknown None Father Mother Brother Sister Son Daughter Other:_________
Hypertension: Unknown None Father Mother Brother Sister Son Daughter Other:_________

Review of Systems: Do you have, have you previously had, or do you take medication for any of the following?

Constitution (General Health)	Yes	No
Developmental Disabilities		
Cancer:____________________		
Fatigue Syndrome		
Other:______________________		
Ear, Nose, and Throat	**Yes**	**No**
Hearing Loss		
Sinusitis		
Dry Mouth		
Laryngitis		
Other:______________________		
Neurological	**Yes**	**No**
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumor		
Stroke		
Migraine		
Autism Spectrum Disorder		
Other:_______________________		
Psychological	**Yes**	**No**
Depression		
Attention Disorder		
Anxiety Disorder		
Bipolar Disorder		
Other:_______________________		
Cardiovascular	**Yes**	**No**
High Blood Pressure (HTN)		
Heart Disease		
Vascular Disease		
Congestive Heart Failure (CHF)		
Other:_______________________		
Respiratory	**Yes**	**No**
Cigarette Smoker		
Asthma		
Bronchitis		
Emphysema		
COPD		
Sleep Apnea		
Other:________________________		

Is there anything else to know about your health?

Gastrointestinal	Yes	No
Crohn's		
Colitis		
Ulcer		
Acid Reflux		
Celiac Disease		
Other:_______________________		
Genitourinary	**Yes**	**No**
Kidney Disease		
Prostate Disease or Cancer		
Benign Prostate Hypertrophy (BPH)		
Pregnant (CURRENTLY)		
Nursing (CURRENTLY)		
Herpes		
Chlamydia		
Other:________________________		
Musculoskeletal	**Yes**	**No**
Arthritis		
Osteoarthritis		
Fibromyalgia		
Muscular Dystrophy		
Ankylosing Spondylitis		
Osteoporosis		
Gout		
Other:________________________		
Integumentary (Skin)	**Yes**	**No**
Eczema		
Rosacea		
Psoriasis		
Herpes Simplex (Cold Sores)		
Herpes Zoster (Shingles)		
Other:_________________________		
Endocrine	**Yes**	**No**
Type 2 Diabetes OR Prediabetes		
Type 1 Diabetes		
Thyroid Dysfunction		
Hormonal Dysfunction		
Other:_________________________		
Hematologic/Lymphatic	**Yes**	**No**
Anemia		
Large-volume Blood Loss		
Ulcer		
High Cholesterol		
Other:_________________________		
Allergy/Immunological	**Yes**	**No**
Rheumatoid Arthritis		
Lupus		
Sjogren's Syndrome		
Other:_________________________		

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Authorization to Release Eye Care / Medical Records

Patient Name:____________________________________ **Date of Birth:** ___________

Address: ____ **Phone:** ________________

Choose one of the following:

[ ] Please release my records (including eyeglasses and contact lens prescriptions) ***FROM*** Conway Eye Care / Coos Eye Care and ***SEND TO*** the following location:

OR

[ ] Please release my records (including eyeglasses and contact lens prescriptions) ***TO*** Conway Eye Care / Coos Eye Care, to be ***SENT FROM*** the following location:

Location Information:

Name:____

Address:____

Phone Number: ________________________ Fax Number: ________________________

Choose one of the following:

[ ] I am only interested in obtaining a copy of my **most recent** medical record. There is no additional charge for this service. ________ Patient Initials

[ ] I am interested in obtaining a copy of **all** medical records on file. I am aware that there will be a charge of $0.50 per page. _________ Patient Initials

This authorization is valid for 60 days from the date of execution. A photocopy of this authorization shall have the same force and effect as an original. **Please allow up to 30 days for processing of records release.**

____ _____________
Patient/Representative Signature Date

____ _____________
Optometrist Signature Date