

Conway Eye Care, N Conway

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Conway Eye Care, Berlin

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Welcome to Conway Eye Care! 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 the important information below.

Scheduling for Routine Care

- **New Patient Registration:** You will be contacted within 30 days of receiving completed registration forms. Non-urgent routine exams for new patients will be added to the waitlist for the new provider arriving summer 2026, and can be added to the waitlist for any cancellations with our current providers.
- **Insurance:** Provide your insurance information before scheduling to avoid delays. If insurance information is unavailable, your visit will be self-pay.
- **Waitlist Option:** Ensure we have your accurate cell number to receive cancellation alerts via text.

Scheduling for New Patient Emergency Care or Problem-Focused Care

- **Emergency Problems or Issues:** Notify our team verbally for proper triage.
- **Non-Emergent Problems:** Expedite care by seeking a referral from your primary care provider (PCP).

Appointment Guidelines

- **Appointment Reminders:** An appointment reminder will be sent by text one month prior to your visit.
- **Required Confirmation:** A confirmation request will be sent by text two weeks prior to your visit. Please reply.
- **Unconfirmed Appointments:** Any appointments not confirmed one week in advance will be contacted by phone. If we are unable to reach you for confirmation, your unconfirmed appointment may be filled from our waitlist.
- **Cancellations:** Provide at least 24 hours notice to avoid a \$50 missed appointment fee and delayed rebooking.
- **Late Arrivals:** In fairness to other patients, arrivals more than 10 minutes late will be rescheduled and are subject to a missed appointment fee.

What to Bring

1. **Insurance Cards:** Present at each visit; outdated or missing information will result in self-pay.
2. **Eyeglasses:** Bring all **current** glasses, including sunglasses, magnifiers, and broken glasses.
3. **Contact Lenses:** Wear your contacts to the visit and bring your prior prescription if not from our office.
4. **Medications:** Provide a list of all current medications, including supplements.

Health & Safety

- **Masks:** Optional, but required if experiencing any respiratory symptoms (cough, congestion, sore throat, fever). COVID-positive patients must wait 10+ days before visiting.

Insurance Coverage

- **Verification:** We do not know what your specific plan covers, so we encourage you to verify prior to your visit.
- **Routine Exams:** Coverage for wellness exams varies by plan. Confirm your benefits directly with your insurer.
- **Medical Visits:** Billable to insurance for conditions like dry eye, diabetes, cataracts, etc (with copay/deductible).
- **In-Network:** Medicare Part B, some Medicare Advantage plans, Blue Cross Blue Shield, Harvard Pilgrim, United Health Care, Cigna, Aetna, Wellsense MEDICARE (not Wellsense MEDICAID), NH Healthy Families, Amerihealth
- **Out-of-Network (unable to submit):** All vision plans (VSP, EyeMed, Davis Vision, etc.), Ambetter, Wellsense MEDICAID, MaineCare, ALL Humana plans (including Humana Medicare Advantage).

I have read and understood the above.

X _____
Patient (or Legal Guardian)

X _____
Signature Date



PATIENT REGISTRATION

Today's Date: _____

Full Name: _____ Preferred Name: _____

DOB: _____ Sex (at birth): _____ Gender: _____ Pronouns: _____

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: _____

If under 18: Parent/Guardian Name: _____ 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: (please complete the following AND include a copy/photo of front and back of card (may send via text/email))

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 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
Do you use any of the following? (Please circle) Contact Lenses Prescription Glasses OTC Glasses

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, Rare: _____ 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	Gastrointestinal	Yes	No
Developmental Disabilities			Crohn's		
Cancer: _____			Colitis		
Fatigue Syndrome			Ulcer		
Other: _____			Acid Reflux		
Ear, Nose, and Throat	Yes	No	Celiac Disease		
Hearing Loss			Other: _____		
Sinusitis			Genitourinary	Yes	No
Dry Mouth			Kidney Disease		
Laryngitis			Prostate Disease or Cancer		
Other: _____			Benign Prostate Hypertrophy (BPH)		
Neurological	Yes	No	Pregnant (CURRENTLY)		
Multiple Sclerosis			Nursing (CURRENTLY)		
Epilepsy			Herpes		
Cerebral Palsy			Chlamydia		
Tumor			Other: _____		
Stroke			Musculoskeletal	Yes	No
Migraine			Arthritis		
Autism Spectrum Disorder			Osteoarthritis		
Other: _____			Fibromyalgia		
Psychological	Yes	No	Muscular Dystrophy		
Depression			Ankylosing Spondylitis		
Attention Disorder			Osteoporosis		
Anxiety Disorder			Gout		
Bipolar Disorder			Other: _____		
Other: _____			Integumentary (Skin)	Yes	No
Cardiovascular	Yes	No	Eczema		
High Blood Pressure (HTN)			Rosacea		
Heart Disease			Psoriasis		
Vascular Disease			Herpes Simplex (Cold Sores)		
Congestive Heart Failure (CHF)			Herpes Zoster (Shingles)		
Other: _____			Other: _____		
Respiratory	Yes	No	Endocrine	Yes	No
Cigarette Smoker			Type 2 Diabetes OR Prediabetes		
Asthma			Type 1 Diabetes		
Bronchitis			Thyroid Dysfunction		
Emphysema			Hormonal Dysfunction		
COPD			Other: _____		
Sleep Apnea			Hematologic/Lymphatic	Yes	No
Other: _____			Anemia		
Is there anything else to know about your health?			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 Records / 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 and **SEND TO** the following location:

OR

Please release my records (including eyeglasses and contact lens prescriptions) **TO** Conway 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.***

X _____
Patient/Representative

X _____
Signature Date

Optometrist

Signature Date