www.conwayeye.com

Conway Eye Care
1319 White Mountain Hwy
North Conway, NH 03860-5155
Phone: (603) 356-3000
Fax: (603) 356-4101

Coos Eye Care
820 Main St
Berlin, NH 03570-2431
Phone: (603) 752-3510
Fax: (603) 752-6887

Welcome to our office!

In order to provide you with the most thorough eye exam; please bring the following to your appointment:

- **All attached paperwork**: Kindly fill out the attached patient information forms in full. These documents will assist your care team in providing the best care for you and accelerating your appointment time. Included in this paperwork is a signature sheet describing some of our policies, such as the Disclosure of Health Information, Dilation, Financial Acknowledgements, and any additional information that your insurance company requires us to provide to you. More detailed information is available in the office when you arrive.
- **Eyeglasses:** Any and all glasses that you currently use, including new and old prescription glasses, sunglasses, over the counter magnifiers, and even broken glasses (we can still measure the prescription and obtain useful information).
- **Contact Lenses:** Please *wear* your current contact lenses to the appointment and *bring* the written contact lenses prescription from your previous doctor.
- **Medications:** A list of all medications that you are taking at this time.
- **Your Insurance Card(s):** Depending on your insurance plan, you may or may not have coverage for a "routine eye exam." Most medical insurances will provide some coverage for medical diagnoses like dry eyes, diabetes, or cataracts; however, please call the number on the back of your insurance card to learn what your specific policy provides and obtain a referral, if necessary, prior to your appointment. You are responsible for understanding your individual insurance policy (including benefits, coinsurances, copays, and deductibles) prior to arrival as each major medical insurance company provides a multitude of plans for patients.

Some of the Insurance Companies that we participate with include, but are not limited to:

- Medicare
- Blue Cross Blue Shield (Anthem)
- Cigna
- Harvard Pilgrim
- NH Medicaid (Traditional Medicaid and New Hampshire Healthy Families)

Please arrive ten (10) minutes prior to your appointment with your insurance cards and paperwork to verify any other information needed prior to your visit.

If you have provided information to receive text or email confirmations, please confirm via text by pressing "C" or via your email when you receive your reminder confirmation alert. As a courtesy to our office and other patients that are waiting for appointments, please allow 24 hours notice to cancel or reschedule any appointment. **Failure to provide 24 hour notice may result in a delay in rescheduling your appointment for up to 90 days.**

Thank you,

Conway and Coos Eye Care

Today's Date:___________________________

Please review and update the information below:

Name: ____ **Nickname**: ________________________

DOB: ___________________ **Gender:** ________________ **Language:** ______________________

Address:____

Home Phone: _______________ **Work Phone:** _______________ **Cell Phone:** _________________

Which number would you like us to call first? (Circle): Home Work Cell

Email: ____

Circle if you would like to OPT OUT of text message reminders: Yes No

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

Employer: ___________________(Circle): Full Time / PT **Position:**__________________________

Who may we thank for referring you to our office today?_________________________________

Insurance:

Insurance Name	Priority	Type	Policy #	Group #

Primary Care Provider/Family Doctor:_______________________

Preferred Pharmacy:________________________

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

HIPAA Policy Acknowledgement:

I acknowledge that I have been provided a copy of the HIPAA policy and practices for Conway/Coos Eye Care which states in part:
I authorize Conway/Coos Eye Care, and its employees and agents to disclose my health care information to health care practitioners and health care facilities who are involved in providing my health care and with my family or close friend who are providing me with emotional support as I receive health care services. I also authorize Conway/Coos Eye Care to disclose my health care information to my health insurance carrier, utilization review organization, or benefit manager to support payment for my health care.

In addition, I am providing my consent to use electronic prescribing in order to send/refill prescriptions to my preferred pharmacy and verify medication lists as available.

Patient/Guardian Signature:______________________________ **Date:** ____________

Additional Permission to Share Information:

I give Conway/Coos Eye Care permission to share my health information with:

Name:________________________ Relationship:_______________ Phone:_______________

Name:________________________ Relationship::______________ Phone:_______________

Patient/Guardian Signature:______________________________ **Date:** ____________

Financial Acknowledgement:

Accounts over 30 days past due will incur a finance charge each month.
Accounts over 90 days past due will be turned over to a collection agency and will incur collection fees.
Accounts turned over to small claims court will incur court charges.
Signature of person financially responsible for account:_________________________

Printed Name:_______________________________ **Relationship:**_________________

Dilation:

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, It is okay to dilate today.

_________ NO, I am refusing dilation and will discuss with the doctor.

Patient/Guardian Signature:______________________________ **Date:** ____________

Optomap (Available in Conway location only):

I have read the information provided regarding optomap retinal screening technology. Please select one and initial:

_________ I elect to get the $39 Optomap screening performed.

_________ I want to speak to the doctor for more information and understand that declining this procedure may limit the doctor's ability to optimally assess my ocular health.

Patient/Guardian Signature:______________________________ **Date:** ____________

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

Race: (Please circle) I decline to provide this information. American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White Other

Ethnicity: (Please circle) I decline to provide this information. Hispanic or Latino Not Hispanic or Latino

---

Medication Allergies: ____

Other Allergies (including LATEX): ____

Please provide a copy of your medicine list:

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

---

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, Socially Yes, Other:____________ None

Tobacco Use: (Circle one) Yes, amount/type:_____________ Former use, Quit date:_________ None

---

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

Cataract: Unknown None Father Mother Brother Sister Son Daughter Other:______

Macular Degeneration: 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:______

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

Review of Systems

Do you have or have you had any of the following? [Please mark yes, if you are taking medication for it.]

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 Deficit		
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	**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:_________________		