Southeast Connecticut Eye Care LLC

Patient Registration Form

Please help us to get to know you and how to contact you.

First name:_____Last Name: _____First name used:_____

Gender: Male___ Female___ Date of Birth:_____/_____/_____Social sec.#_____-_____-_____

Mailing address:
Street:_____

City:_____ State_____Zip:_____

Home Phone:_____Cell:_____Work:_____Ext_____

Preferred method of contact: (circle one) Home phone Cell Phone Work Phone

Consent to automated text alerts? (appointment confirmation): Yes_____ No_____
Consent to automated phone call alerts? (appointment confirmation): Yes_____ No_____

Email:_____

Marital status: (circle one) Single Married Divorced Separated Widowed Partner

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How did you hear about us? (please circle one)

The Day The Bulletin Word of Mouth Referral Insurance Primary Care Physician

Internet Search Other_____

Emergency contact name:

_____Relationship:_____

Home Phone:_____Cell:_____

GLASSES and CONTACT LENS CHARGES (ALL PATIENTS PLEASE INITIAL):
A refraction allows us to take a measurement of the focusing characteristics of the eye. This measurement also determines your eyeglass prescription. This fee is often not covered by Medicare or private health insurances. If you prefer not to have a refraction done, please let the technician know at the time of your visit.

All contact lens wearers must have a yearly contact lens evaluation. This evaluation allow us to update expired contact lens prescriptions, detect and manage any problems with contact lenses or eye health, offer recommendations on the latest technology in contact lenses and eye wear, and to properly monitor our patients. There is a fee associated with this evaluation each year that is typically not covered by insurance.

_____**Initials**

Certification: I agree to the **Terms and Conditions of Care** and accept the **Privacy Practices** (as amended from time to time and available at SEE-CARE.com and in paper form by request) and wish to become a patient at Southeast Connecticut Eye Care LLC.

Signature:_____Date:_____

☐ Check here if the signer is the patient's Power of Attorney or legal guardian.

First name:_____Last Name:_____DOB:____/_____/_____

Primary Insurance:_____

Policy number:_____
Policy Holder (if different from patient):
First name_____Last Name_____
Address:_____
DOB:____/____/_____ Male____Female____

Secondary Insurance:_____

Policy number:_____
Policy Holder (if different from patient):
First name_____Last Name_____
Address:_____
DOB:____/____/_____ Male____Female____

Tertiary Insurance:_____

Policy number:_____
Policy Holder (if different from patient):
First name_____Last Name_____
Address:_____
DOB:____/____/_____ Male____Female____

PRIMARY CARE DOCTOR AND PHARMACY INFO:

Who is you primary care doctor (or Physician's Assistant/Nurse Practitioner)?

First and last name:_____
Town:_____State:_____

Who is your most recent primary eye doctor?

First and last name:_____
Town:_____State:_____

Please list your other doctors (first and last name, specialty, town, state):_____
_____
_____
_____

Which Pharmacy do you use (include town)?

_____ Town_____

First name:_____Last Name:_____DOB:____/_____/_____

EYE HISTORY:

Do you have or had any of these conditions? Please circle all that apply

Glaucoma	Cataract	Dry eyes	Macular degeneration
Eye allergies	Retinal hole/tear or detachment	Diabetic eye disease	Contact lens wear

Other_____

EYE SURGERIES:

What eye surgeries and procedures have you had and when? Please circle all that apply.

Cataract surgery	Glaucoma surgery	Eyelid surgery	LASIK/PRK
Laser after cataract surgery	Laser for narrow drainage system	Retinal laser	Retinal detachment surgery

Other_____

EYE DROP MEDICATIONS:

Please list eye drops you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY:

Do you have any of these conditions? Please circle all that apply.

Diabetes	Hypertension	Stroke	Heart attack	Rheum arthritis	Sjogren's
Asthma	COPD	Thyroid disease	Pacemaker	Defibrillator	Migraine

Other_____

OTHER SURGERIES: **Please list surgeries you have had, and when you had them:**

_____

_____

MEDICATIONS: **Please list any medications you are taking including non-prescription, or attach a list. We normally don't need the doses.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: **What allergies do you have (including allergies to medications or latex)?**

_____

_____

_____