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: ______________________Nick Name used:______________

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

Street:____

City:______________________________________ State___________Zip:___________________

Email:____

Cell Phone:_________________ Consent to automated phone call alerts? Yes_____ No________
Consent to automated text alerts? Yes______ No________

Home Phone:______________________Work Phone:_________________

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

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

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NEW PATIENTS - 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.** For general eye care patients, we normally perform a refraction at least every two years.

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. Charges for refractions and contact lens evaluations are posted on our website.

_______**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 CARE DOCTOR AND PHARMACY INFO:
Who is your primary care doctor (or Physician's Assistant/Nurse Practitioner)?
First and last name:____
Town:___________________________________State:___________

Which Pharmacy do you use (include town)?
____ Town__________________________

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

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

Other____

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

RIGHT EYE		LEFT EYE	
Cataract surgery	Date__________	Cataract surgery	Date__________
Glaucoma surgery	Date__________	Glaucoma surgery	Date__________
Laser after cataract surgery	Date__________	Laser after cataract surgery	Date__________
Eyelid surgery	Date__________	Eyelid surgery	Date__________
Lasik/PRK	Date__________	Lasik/PRK	Date__________
Laser for Narrow drainage system	_________	Laser for Narrow drainage system	__________
Retinal laser	Date__________	Retinal laser	Date__________
Retinal detachment surgery	Date__________	Retinal detachment surgery	Date__________

Other____

EYE DROP MEDICATIONS:
Please list eye drops you are taking: Including over the counter eye drops

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)?**