Southeast Connecticut Eye Care, LLC

New Patient Welcome Packet

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

First name:_____ Last name:_____ Preferred name:_____

Date of Birth:_____ Social sec. #:_____-____-_____ Gender: male female

Mailing address:_____ City:_____ State:_____ Zip:_____

Home tel:_____ Cell:_____ Offc. tel:_____

Email:_____ Preferred appointment reminders (circle): Text / Email / Telephone

Emergency contact name:_____ Tel:_____ Relationship:_____

Primary insurance company:_____ Policy number:_____

Policy holder (if different than the patient):

First name:_____ Last name:_____ Date of Birth:_____

Gender (circle): male / female Relationship to patient:_____

Secondary insurance company:_____ Policy number:_____

Policy holder (if different than the patient):

First name:_____ Last name:_____ Date of Birth:_____

Gender (circle): male / female Relationship to patient:_____

Third insurance company:_____ Policy number:_____

Policy holder (if different than the patient):

First name:_____ Last name:_____ Date of Birth:_____

Gender (circle): male / female Relationship to patient:_____

Certification: I have been provided with a copy of the Terms and Conditions for Care and Notice of Privacy Practices, in web (see-care.com) and/or paper form and have read them. I agree to the Terms and Conditions of Care and accept the Privacy Practices 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

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New Patient Medical History

Your first name:_____ Last name:_____ Date of birth:_____

Please list any eye conditions and/or diseases you have:

What eye surgeries and procedures have you had? When?:

Who is your most recent primary **eye** doctor?

First and last name:_____ Town:_____ State:_____

Please list any other eye doctors (first and last name, specialty, town, state) involved in your care:

Please list your general medical conditions (e.g. diabetes, high blood pressure):

Please list surgeries you have had, and when you had them:

Please list your medications (we don't need doses, attach a sheet or continue on the other side if needed):

What allergies do you have (including allergies to medications)?

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

First and last name:_____ Town:_____ State:_____

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