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 Contact: (circle) Home phone Cell Phone Work Phone

Marital Status: (circle) Single Married Divorced Separated Widowed Partner

Gender Identity: (circle) Male Female Transgender_____ Other_____ Choose Not to Say

Sex at Birth: (circle) Male Female Choose Not to Say

Pronouns: (circle) He/Him She/Her They/Them

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)?**

_____

_____