

## Welcome to Suwanee Vision Center

**Patient Information** \_\_\_\_\_ Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Email \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Date of Last Eye Exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Referred By \_\_\_\_\_

### **Insurance Information**

Vision Insurance Company \_\_\_\_\_ Health Insurance Company \_\_\_\_\_  
Primary Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Phone Number \_\_\_\_\_

### **Health History**

Do you or anyone in your immediate family have a history of the following:

High blood pressure \_\_\_ Diabetes \_\_\_ Thyroid \_\_\_ Glaucoma \_\_\_ Cataracts \_\_\_

Blindness \_\_\_ Heart Condition \_\_\_ Turned or lazy eye \_\_\_

Condition and relation \_\_\_\_\_

### **Medical Information**

Please check any of the following conditions that apply to you:

Frequent Headaches \_\_\_ Pregnant \_\_\_ Allergies \_\_\_ Sinus Trouble \_\_\_

Allergies to medication Yes/No \_\_\_\_\_

Current medications \_\_\_\_\_

Have you ever had any of the following conditions involving your eyes?

Eye Surgery \_\_\_ Eye Injury \_\_\_ Medical treatment \_\_\_ Severe pain \_\_\_ Eye strain \_\_\_

Sensitivity to light \_\_\_ Poor near vision \_\_\_ Poor distance vision \_\_\_ Spots \_\_\_

Eyes burn itch or water \_\_\_ Eye infection or disease \_\_\_

Do you currently wear glasses Yes/No for what reason \_\_\_\_\_

Do you currently wear contact lenses Yes/No what type \_\_\_\_\_

### **Certification and Assignment**

To the best of my knowledge, the above information is complete and correct, I understand that it is my responsibility to inform my doctor if I, or my minor child ever had a change in health. I certify that I have insurance coverage with \_\_\_\_\_ and assign directly to Dr.Reddy all insurance benefits. I understand I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature \_\_\_\_\_ Date \_\_\_\_\_