

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 _____