The Vision Center
AT CASCADE PARK

NAME: Last: _______________________________ First: ___________________________ MI: ____ Suffix: _____

Date of Birth: ____________________________ Gender: M F Other:

Address _____________________________ Apt: ______ Preferred Phone: _____________________

City/State/zip _____________________________________ Alternate Phone: _____________________

Email: ____ Last 4 of SSN: ________________

(*only for communication from our office. We do NOT share/sell patient information*) *(Sometimes needed for insurance verification)*

How did you hear about our office?

- o I am a previous patient of Dr. Johnson
- o Insurance list of providers
- o Google search
- o Mountain View High School basketball
- o Ridgefield Craft Brewery
- o Be Local magazine
- o Funemployment Radio
- o Other ________________________________

Who is responsible for this account? o Self (continue to insurance section below)

o Other: First Name ___________________________ Last Name: __________________________________

Phone: ______________________________ Relation to patient: ___________________________

Vision Insurance Information

o I am not covered by a vision insurance policy (Continue to Medical Insurance section)

Primary Vision Insurance Company: ____

Subscriber Information: o Same as Patient ID number: _____________________________ Last 4 of SSN: _________

First name: _____________________________ Last name: _____________________________ DOB: _________________

Secondary Vision Insurance Company: ____

Subscriber Information: o Same as Patient ID number: ________________________________

First name: _____________________________ Last name: _____________________________ DOB: _________________

Medical Insurance Information

o I am not covered by a medical insurance policy

o My medical insurance is the same as my vision insurance policy

Primary Medical Insurance Company: ____

Subscriber Information: o Same as Patient ID number: _________________________________

First name: _____________________________ Last name: _____________________________ DOB: _________________

Secondary Medical Insurance Company: ____

Subscriber Information: o Same as Patient ID number: ________________________________

First name: _____________________________ Last name: _____________________________ DOB: _________________

First name: ____

Last eye exam date (or estimate): ___________________________________

Do you wear glasses? o No o Yes: o Single Vision o Bifocal o Trifocal o Progressive

When do you wear your glasses? o All the time o Only for distance o Only for near o Backup for contacts

Do you wear contact lenses? o No o Yes If yes, what kind or brand? ______________________________

Occupation: ____________________________ Hobbies: _______________________________________

Are you having any of the following eye concerns?	Are you having any of the following vision concerns?	Have you ever been diagnosed with the following?
o Redness	o Blurred Vision	o Cataract
o Burning	o Eyestrain	o Macular degeneration
o Itching	o Eye Pain	o Glaucoma
o Tearing	o Severe sensitivity to light	o Diabetic retinopathy
o Discharge	o Headaches	
	o Poor night vision	
	o Bothersome night glare	
	o Double Vision	

Do you have any other eye conditions not listed above?

Do you have any history of eye injuries or surgeries?

____

Are you currently using any eye drops or ocular medications?

____

Do you have any medical conditions? If yes, please list.

____

Do you have: o Diabetes o Hypertension o High cholesterol

Are you currently taking any prescription medications? If yes, please list. Attach a separate list if necessary. (Dosage not needed)

____

Do you have any allergies to medications? If yes, please list medication and reaction.

____

Do you use tobacco products? o No o Yes

Do you have FAMILY HISTORY of the following? If yes, please list relationship.

o High blood pressure ____________________	o Glaucoma ____________________
o Diabetes ____________________	o Macular degeneration ____________________