Jeffrey C. Minor, OD

Patient Information

NAME	HOME/CELL PHONE	WORK PHONE
ADDRESS		
CITY	STATE	ZIP

BIRTH DATE	SOCIAL SECURITY NUMBER	EMPLOYER / SCHOOL

NAME OF SPOUSE (if married) OR PARENT			
NAMES OF CHILDREN / SIBLINGS	AGE		AGE

DATE OF LAST EXAM & DOCTOR'S NAME	EXAMINATION WAS FOR ( ) GLASSES ( ) CONCTACTS ( ) BOTH

PLEASE MARK ALL THAT APPLY

( ) HISTORY OF EYE DISEASE – SELF OR FAMILY ( ) ANY EYE SURGERY – DATE/TYPE _____

( ) DIABETES ( ) SINUS TROUBLE ( ) HIGH BLOOD PRESSURE ( ) ALLERGIES ( ) PREGNANT

LIST ANY MEDICATIONS YOU PRESENTLY USE

LIST DRUG SENSITIVITIES

IF YOU WEAR GLASSES, WHEN ARE THEY WORN

( ) ALL THE TIME ( ) DISTANCE CORRECTION ( ) READING ( ) COMPUTER ( ) DRIVING/OUTDOORS

IF YOU HAVE WORN CONTACTS BEFORE , WHAT TYPE WERE THEY

( ) SOFT DISPOSABLE ( ) RIGID GAS PERMEABLE

IF YOU HAVE VISION COVERAGE, WHAT IS THE NAME OF THE PLAN

( ) SPECTERA/UHC VISION ( ) DAVIS VISION ( ) EYEMED ( ) ALWAYS VISION ( ) SUPERIOR VISION

( ) TRICARE ( ) VCP-VISION CARE PLAN

HOW WERE YOU REFERRED TO US

EMAIL ADDRESS