Valley Eye & Laser Center / Valley Optical
Jonathan D. Jahnke, MD
Ophthalmologist, Physician and Surgeon

Name: _____
First Middle Last

Preferred Name: _____

Sex: Male / Female Date of Birth: _____/_____/_____ Age: _____

Mailing Address: _____

City, State, Zip: _____

Main Phone: ( ) _____ - _____ Other: ( ) _____ - _____

E-mail Address: _____

Social Security Number: _____ - _____ - _____

Marital Status: Single Married Divorced Widowed

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: ( ) _____ - _____

Relationship to Patient: _____

Referring OR Primary Care Physician: _____

Medical Insurance Carrier: _____

Vision Insurance Carrier: _____

_____ _____
Patient/Patient Representative Signature **Date**

307 E Hancock St, Newberg OR 97132 Phone: 503.538.2010, Fax: 503.554.9549

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Jonathan D. Jahnke, MD
Ophthalmologist, Physician and Surgeon

Patient Name: _____ Date of Birth: _____

Please List ALL Prescription Medications

Medication	Dose	Times per day

Medication Allergies
(please only list allergies to medications)

_____

_____

_____

_____

_____

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