



Our Mission: Your Best Vision

**Please Fax New Patient Referrals to (864) 458-3894**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Patient Insurance Information**

**Primary Insurance Co:** \_\_\_\_\_ **Authorization #:** \_\_\_\_\_  
Effective Date of Policy: \_\_\_\_\_ **Group/Plan #:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_  
**Secondary Insurance Co:** \_\_\_\_\_ **Authorization #:** \_\_\_\_\_  
Effective Date of Policy: \_\_\_\_\_ **Group/Plan #:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Referring Physician Information**

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Referring Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_ Is this an urgent referral? Y N  
*For urgent referrals, please fax this form and call 864-458-3800 to ensure that the patient is scheduled appropriately.*  
**In order to schedule the appointment, please submit the following required medical records:**

- **Last 3 office visits, plus any testing performed**
- **Glaucoma Referrals – please send exam notes from prior 3 years, plus all Visual Field/OCT testing performed**
- **Copy of the front and back of the patient’s insurance card**

Specify Physician (Optional): \_\_\_\_\_