JERVEY EYEGROUP

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:

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

Specify Physician (Optional): _____

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