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 864-458-3900 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): ____