REQUEST FOR VITREORETINAL CONSULTATION

RETINA
CONSULTANTS OF FLORIDA

PATIENT'S NAME _____ PATIENT'S PHONE NUMBER _____

REFERRING PHYSICIAN

Dr. _____ **Tel:**_____ **Fax:**_____

PATIENT'S MEDICAL INSURANCE:_____

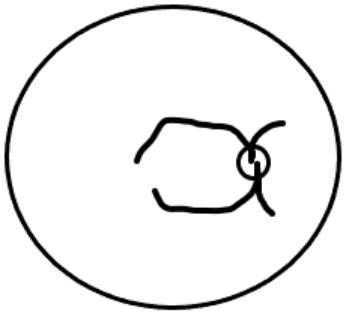
DIAGNOSIS:_____

OCULAR HISTORY:

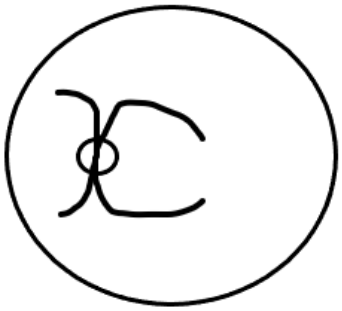
_____

_____

_____



OD



OS

PATIENT APPOINTMENT CONFIRMATION:

DATE &TIME:_____

INSTRUCTIONS FOR PATIENT

- PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT WITH DR. REINHERZ.
- YOUR EYES WILL BE DILATED. WE ADVISE THAT YOU BRING A DRIVER AND SUNGLASSES. YOU WILL BE IN THE OFFICE APPROXIMATELY 1-3 HOURS.
- BRING YOUR HEALTH INSURANCE CARD(S) AND A STATE ISSUED PHOTO ID

BENJAMIN REINHERZ, DO PA

11900 BISCAYNE BLVD, SUITE 806

NORTH MIAMI, FL 33181

PHONE: 305-830-4115 FAX: 305-697-9717