PATIENT INFORMATION

☐ CHECK IF STAT



1701 Magnolia Way, Suite 201 Augusta, GA 30909 p: (706) 426-7342

Monday - Friday gam to 4pm

DATE OF REFERRAL

Sohail Khan, MD
Ophthalmology | Vitreous and Retinal Surgery

Patient's Name (First, Middle, Last)								Birth Date (MM/DD/YYYY)			
Sex  Male Female					Interpreter Needed? ☐ Yes ☐ No ☐ If YES: ☐ Spanish ☐ Other:						
Address City			State			State	State ZIP o		е		
Preferred Phone  cell home work	Patient's Email Address										
Insurance & Plan Name (please also attach copy of insurance card)				Name, Relationship & DOB of Primary Insured (if not patient)							
REASON FOR CONSULT										- h A	
Appointment Type					Notes:						
☐ General Ophthalmology	RT	LT									
☐ Wet AMD	RT	LT									
☐ Dry AMD	RT	LT									
☐ BRVO/CRVO	RT	LT									
☐ Retinal Tear/Break/Detachment	RT	LT									
☐ Peripheral Vitreous Detachment	RT	LT									
☐ Epiretinal Membrane	RT	LT									
☐ Diabetic Macular Edema	RT	LT									
☐ Non-proliferative Diabetic Retinopathy	RT	LT									
☐ Proliferative Diabetic Retinopathy	RT	LT						×	7	(	
☐ Vitreous Hemorrhage	RT	LT									
☐ Macular Hole	RT	LT									
Other:	RT	LT									
REFERRING PROVIDER INFORMATION	l				=		1	ø	w.		
Referring Provider's Name Re				eferring Provider's Email					Cell (for emergencies)		
Practice Name and Address								Provider	NPI (Indiv	vidual)	
Referral Coordinator Contact Name & Email					Phone			L	Fax	<	
How would you like for us to send you Progress N									,		

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## **INSURANCES WE ACCEPT**

Medicare Tricare (all policies) United Healthcare Anthem BCBS (non-pathway)
Humana Aetna Cigna Coventry All Medicare Advantage Plans

Most major insurance accepted