

Sohail Khan, MD
Ophthalmology | Vitreous and Retinal Surgery

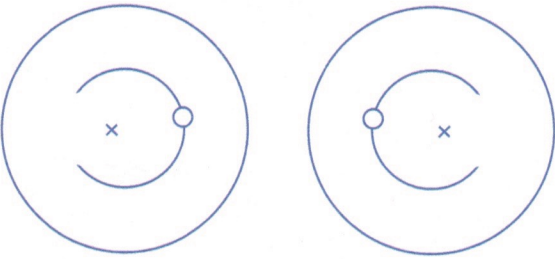
PATIENT INFORMATION

DATE OF REFERRAL _____

Patient's Name (First, Middle, Last)			Birth Date (MM/DD/YYYY)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Address		City	State	ZIP code
Preferred Phone <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> 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

Appointment Type	Notes:	
<input type="checkbox"/> General Ophthalmology	RT LT	
<input type="checkbox"/> Wet AMD	RT LT	
<input type="checkbox"/> Dry AMD	RT LT	
<input type="checkbox"/> BRVO/CRVO	RT LT	
<input type="checkbox"/> Retinal Tear/Break/Detachment	RT LT	
<input type="checkbox"/> Peripheral Vitreous Detachment	RT LT	
<input type="checkbox"/> Epiretinal Membrane	RT LT	
<input type="checkbox"/> Diabetic Macular Edema	RT LT	
<input type="checkbox"/> Non-proliferative Diabetic Retinopathy	RT LT	
<input type="checkbox"/> Proliferative Diabetic Retinopathy	RT LT	
<input type="checkbox"/> Vitreous Hemorrhage	RT LT	
<input type="checkbox"/> Macular Hole	RT LT	
<input type="checkbox"/> Other: _____	RT LT	



REFERRING PROVIDER INFORMATION

Referring Provider's Name		Referring Provider's Email	Cell (for emergencies)
Practice Name and Address			Provider NPI (Individual)
Referral Coordinator Contact Name & Email		Phone	Fax
How would you like for us to send you Progress Notes? <input type="checkbox"/> By Fax <input type="checkbox"/> By Mail <input type="checkbox"/> By Email (HIPAA compliant) _____			

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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