Eyecare Medical Group
Tomorrow's eyecare today.

REQUIRED INFORMATION FOR APPOINTMENT SCHEDULING

Referring PCP: (First, Last, Phone, Fax #s) _____

_____

Patient Name: _____ **DOB:** _____

Address: _____

Phone Number: _____ **Sex:** □ **Male** □ **Female**

Preferred Eyecare Medical Group Physician: _____ ☐ **No preference**

Current Eye Doctor (OD/MD), (First, Last, Phone #) _____

Last seen by current Eye Doctor _____

Diabetic? □ **Yes** □ **No** **Interpreter required?** □ **Yes** □ **No** **Language** _____

Insurance: _____ **ID#**_____ **Subscriber** _____

Diagnosis: _____ **Duration of Symptoms** _____

Symptoms: _____

_____

PLEASE FAX THIS DOCUMENT TO TRIAGE @ (207) 791.8243

Office Use Only:

Appointment Date/Time: _____ Doctor: _____

Suggested referral to: _____

Date Faxed: _____