METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Ophthalmology

Request for Appointment

PLEASE FAX FORM AND ANY PHYSICIAN NOTES/LETTER AND DIAGNOSTIC TESTS TO 616.252.5744

Date: ______________________

Patient Information

Last Name: ______________________ First Name: ______________ Middle Initial: ____

Sex: ☐ M ☐ F ______________________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Cell Phone: ( ) ____________

Address: ______________________ City: ______________ Zip: ________

Emergency Contact: ______________ Relationship: ________ Phone: ( ) ____________

Primary Care Physician: ______________________ ☐ DO ☐ MD
(First and Last Name)

Primary Insurance: ______________________ Policy #: ______________

Secondary Insurance: ______________________ Policy #: ______________

Interpreter Needed: ☐ Yes ☐ No If yes, indicate language: ______________________

Appointment Information

Office Location: ☐ Wyoming ☐ Rockford

Appointment Preference: ☐ AM ☐ PM ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Reason for Referral (diagnosis): ______________________

Referring to: ☐ Douglas Doyle, DO ☐ Paul Brown, DO ☐ Matthew Borr, DO

Referring Physician: ______________________ ☐ MD ☐ DO ☐ OD

Address: ______________________

Phone: ( ) ____________ Fax #: ( ) ____________ Contact Person: ______________

Do you want to:

CO-MANAGE: ☐ Yes ☐ No See patient for FINAL REFRACTION: ☐ Yes ☐ No

OFFICE USE ONLY

Appt scheduled for: ____________ at____________ with Dr. ______________________

in the ______________________ office Faxed to office on ______________ by______________

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METRO HEALTH OPHTHALMOLOGY

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