NEVADA RETINA ASSOCIATES

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☐ Dr. Friedlander ☐ Dr. Geraymovych ☐ Rob Welch, FNP ☐ City

Date: _____ **Appt Date:** _____ **Reno or Carson** **Chart No:** _____

Patient Name: _____ **DOB:** _____
(First) (Last)

Existing Patient: ☐ **Yes** ☐ **No** **Year:** _____ **MD:** _____ **Location:** _____ **Chart Ordered:** ☐

Primary Ins: _____ **Secondary Ins:** _____ **Gender:** ___

Home Phone #: _____ **Cell Phone/Other #:** _____

Address: _____

_____

Referring M.D.: _____ MD OD DO NP PA

Speaking to: _____ **Phone #:** _____ **Fax #:** _____

Call taken by: _____ **Patient's Email Address:** _____

Requested: **Referral Notes** ☐ **Insurance Cards** ☐
Demographics ☐ **Translator Required** ☐

FOR TECHNICIAN USE ONLY:

Patient to be seen for: _____

Vision: **OD 20/_____** **OS 20/_____** **Circle One:** **CC or SC**

Affected eye: **OD** **OS** **OU**

Notes:

_____

_____

Schedule within: _____ **Procedures:** _____

Tech triaging call: _____ **M.D. Review:** _____

Notes: _____

_____

New Patient Packet sent: _____ (Date/Initial) _____

Revised: 9/14/2020