



# Vitreous Retina Macula Consultants of New York, P.C.

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Referred By: \_\_\_\_\_

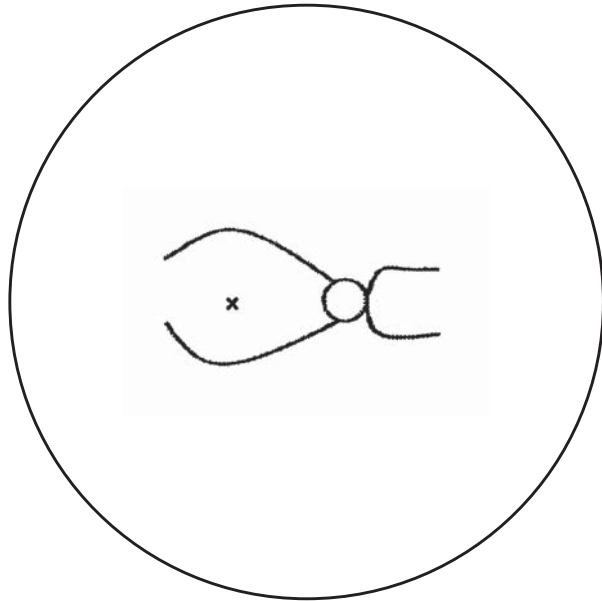
Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

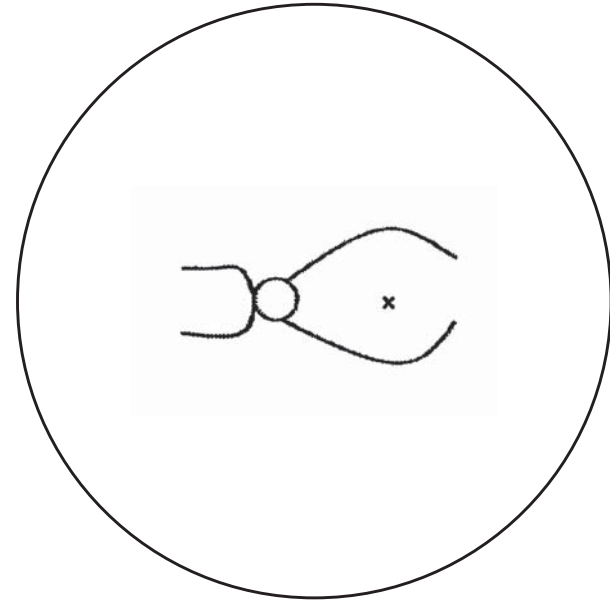
D.O.B. \_\_\_\_\_

## INSTRUCTIONS TO PATIENT:

- PLEASE BRING THIS FORM WITH YOU TO OUR OFFICE.
- YOUR EYES WILL MOST LIKELY BE DILATED.
- YOU WILL BE IN OUR OFFICE A MINIMUM OF TWO (2) HOURS.
- IF YOU NEED A REFERRAL FROM YOUR INSURANCE PLAN, PLEASE BE SURE TO OBTAIN ONE PRIOR TO YOUR VISIT.
- PLEASE BRING CURRENT INSURANCE CARD(S) WITH YOU.



Right Eye



Left Eye

Reason for Consultation: \_\_\_\_\_

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