Patient Referral

Taylor Retina Center

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Jeffrey Taylor, M.D.
Nitin Gupta, M.D.
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Patient's Name: _____ **Exam Date:** _____

Referring Physician: _____ **Diagnosis:** _____

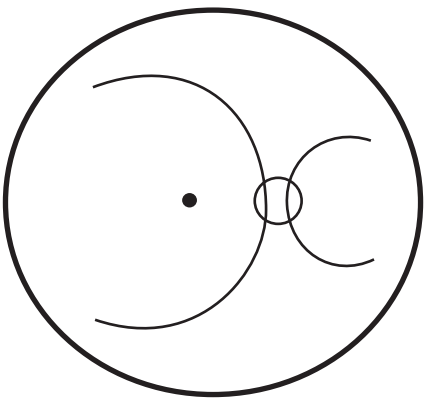
Ocular History: _____

_____

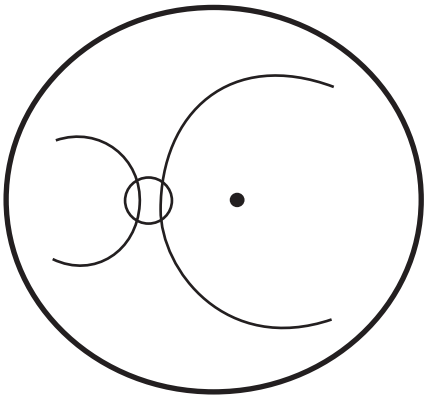
_____

Indicate area of concern:

OD



OS



INSTRUCTIONS TO PATIENT:

Please bring this form with you to our office.
Your eyes will be dilated and you may want to have a driver.
Please bring your insurance information and referral forms, if required.

DIRECTIONS AND MAPS ON THE REVERSE SIDE.