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Purpose of Visit: ______________________________

Patient Name: ______________________________

Diabetic: ☐ YES ☐ NO   If yes attach A1C

SSN: ______________ DOB: ______________

Address: ______________________________

Home #: ______________ Cell #: ______________

Referring Physician: ______________________________

Contact: ______________ Phone #: ______________ Fax #: ______________

Primary Insurance: ______________ Policy #: ______________

Secondary Insurance: ______________ Policy #: ______________

****PLEASE FAX THE PATIENT'S MEDICATION LIST, PRESCRIPTION DRUG CARD and AVAILABLE NOTES. IF DIABETIC, PLEASE FAX THE MOST RECENT A1C.**

FAX 912-406-2595

Appointment Date:______________________ Time: ______________________

Contact: ______________________.