

Atlantic *eye* Institute

Live your vision.™

Patient Name: _____

Date of Birth: _____ Phone: _____

Referring Doctor: _____

Phone: _____ Fax: _____ Today's Date: _____

Please call to schedule -or- Appointment Date: _____ Time: _____

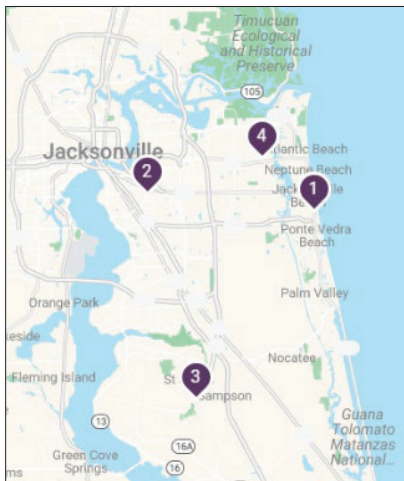
Reason for Referral:

- | | | | | |
|-------------------------------------|--|---|--|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Oculoplastics | <input type="checkbox"/> Corneal Crosslinking | <input type="checkbox"/> Retina | <input type="checkbox"/> Corneal Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> LASIK / PRK | <input type="checkbox"/> Diabetic Eye Exam | <input type="checkbox"/> Low Vision | <input type="checkbox"/> Botox / Dermal Fillers |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Eye Exam | <input type="checkbox"/> Glasses & Contacts | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Implantable Contact Lens |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Prism Glasses | <input type="checkbox"/> Neuro-Ophthalmic Disease | | |
- Other: _____

Our Doctors:

- | | |
|---|--|
| <input type="checkbox"/> Charles V. Duss, MD | <input type="checkbox"/> C. Steven Lancaster, OD, FAAO |
| <input type="checkbox"/> Karim J. Samara, MD | <input type="checkbox"/> Danielle T. Callegari, OD, FAAO |
| <input type="checkbox"/> Michelle L. Diaz, MD | <input type="checkbox"/> Austin R. Felver, OD |
| <input type="checkbox"/> Sushma K. Vance, MD | <input type="checkbox"/> Kelsey M. Mileski, OD, FAAO |
| <input type="checkbox"/> Sheila Pabon, MD | <input type="checkbox"/> Christen R. Russell, OD |

Our Locations:



- #1 Beaches:** 3316 Third Street South, Suite 103, Jax Beach, FL 32250
- #2 Southside:** 6207 Bennett Road, Jacksonville, FL 32216
- #3 St. Johns:** 105 Nature Walk Pkwy, Ste 105, St. Augustine, FL 32092
- #4 Intracoastal:** 13457 Atlantic Boulevard, Ste 5, Jacksonville, FL 32225