



FLORIDA RETINA INSTITUTE

Vitreous - Retinal Diseases and Surgery

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Patient: _____

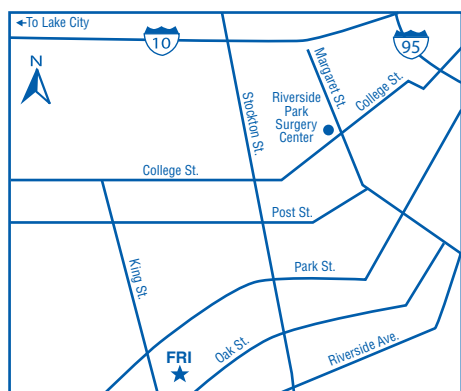
D.O.B.: _____

Patient Phone #: _____

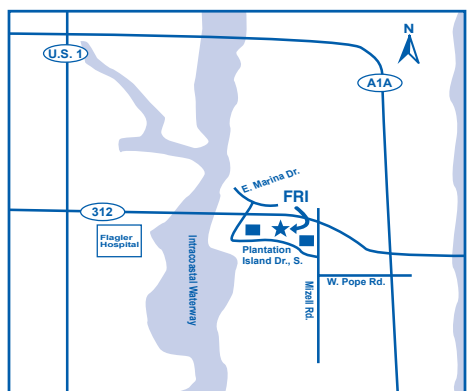
Referring Doctor: _____

Diagnosis/Reason for Referral:

Appointment: Date _____ Time _____



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