THE SINUS CENTER OF South Carolina
www.sinuscentersc.com

Benjamin D. Paysinger, Jr., M.D. Tab E. Thompson, M.D. Anna Lee Bouknight, M.D.
T: (803) 451-0491 F (803) 256-0961

APPOINTMENT REQUEST FORM

Patient Information

PATIENT NAME _____ ☐ MALE ☐ FEMALE

GUARDIAN NAME (IF MINOR) _____

DATE OF BIRTH ____ / ____ / ____ PATIENT'S SSN ____ - ____ - ____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) ( ) - (WORK) ( ) -

INSURANCE _____ ID # _____

Physician Preference

- ☐ BENJAMIN D. PAYSINGER, JR., M.D., F.A.C.S.
- ☐ TAB E. THOMPSON, M.D., M.B.A., F.A.C.S.
- ☐ ANNA LEE BOUKNIGHT, M.D.
- ☐ NO PREFERENCE

Office Preference

- ☐ ONE WELLNESS BLVD., SUITE 101
  IRMO, SC 29063
- ☐ 2750 LAUREL ST., SUITE 203
  COLUMBIA, SC 29204

Referring Physician

REFERRING PHYSICIAN _____

OFFICE CONTACT NAME _____

OFFICE PHONE ( ) - FAX ( ) -

REASON FOR REFERRAL _____

_____

☐ CONSULT FOR IN OFFICE BALLOON SINUS DILATION

- IF THE PATIENT HAS HAD A CT, MRI OR XRAY THAT PERTAINS TO THIS APPOINTMENT, PLEASE HAVE THE PATIENT BRING THE FILMS WITH THEM.
- PLEASE FAX RELEVANT NOTES / RECORDS WITH THIS FORM TO (803) 256-0961
- IF REFERRAL IS REQUIRED, PLEASE FAX TO (803) 256-0961

Office Use Only

APPT DATE ____ / ____ / ____ APPT TIME ____ : ____

☐ PATIENT NOTIFIED
☐ REFERRING OFFICE NOTIFIED