

**GREGORY J. MACKAY, M.D.
DONALD R. NUNN, M.D.
M. SUSANN BEDFORD, M.D.
5673 PEACHTREE DUNWOODY ROAD
SUITE 870
ATLANTA, GA 30342**

PATIENT REFERRAL FORM

Please provide the COMPLETE name, address and phone number of the **physician who referred you** to Dr. Mackay, Dr. Nunn, or Dr. Bedford. Check N/A if you were not referred by a physician.

_____ N/A

Physician Name_____

Address_____

Phone (____)_____

Please indicate any **physician you'd like us to transfer your records to** if different than above:

Physician Name_____

Address_____

Phone (____)_____

* If you were not referred by another physician, how did you hear about our office?

