

## PATIENT REFERRAL FORM

### Instructions:

1. Please print the most current information for the patient as requested below. Please be sure to complete all sections.
2. Fax this form to our referral fax line: (559) 432-6195.
3. Within 24 hours, we will fax back an Appointment Verification Form showing the date and time of the appointment for this patient.
4. Upon your receipt of our form, please notify the patient of the appointment date and time. (Note: we do not contact the patient at the time the appointment is made)

\*\*\* **Please Print** \*\*\*

### Patient Information:

Patient's Full Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Patient's Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) Cell Phone (\_\_\_\_) \_\_\_\_\_

*Note: Please include all phone numbers you have available.*

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status:  Single  Married  Other Sex:  Male  Female

Emergency Contact/Message: Full Name \_\_\_\_\_ Phone # \_\_\_\_\_

### Insurance Information:

#### Primary Insurance Coverage

#### Secondary Insurance Coverage

Insurance Company \_\_\_\_\_

Type  HMO  PPO  HMO Sante  HMO  PPO  HMO Sante

*Note: Please include Secondary Insurance Coverage when applicable.*

### Physician Information:

Referring Physician M.D. \_\_\_\_\_ NPI# \_\_\_\_\_ Fax #: \_\_\_\_\_

(please list Supervising Physician for P.A or N.P.)

Diagnosis Description (not code): \_\_\_\_\_ D.O.I. \_\_\_\_\_

CCENT Physician Requested: \_\_\_\_\_

**Please send us your records pertaining to this diagnosis.**

**If patient has had diagnostic tests, please have them bring films/scans with them.**

**Thank You For Your Referral**