Plastic & Reconstructive Surgery

(256) 265-6851
f: (256) 265-6869

Referral to: Tony L. Weaver, DO

Referral From: ______________________

Diagnosis: ______________________

Scheduled By: ______________________ Person Calling: ______________________

Referral Date: ______________________ Office Number: ______________________

Patient Name: ______________________

Date of Birth: ______________________ Social Security #: ______________________

Home Address: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Insurance/PrimaryName: ______________________

Policy#: ______________________ Group#: ______________________

Date of Appointment: ______________________

Insurance Information *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: ______________________ Relationship to patient: ______________________

Subscriber's name: ______________________ Copay amount: ______________________

Subscriber ID/Contract Policy #: ______________________ Group #: ______________________

Subscriber's SSN: ______________________ Subscriber's DOB: ______________________

Subscriber's Employer: ______________________ Employer's Phone: ______________________

SECONDARY INSURANCE

Insurance name: ______________________ Relationship to patient: ______________________

Subscriber's name: ______________________ Copay amount: ______________________

Subscriber ID/Contract Policy #: ______________________ Group #: ______________________

Subscriber's SSN: ______________________ Subscriber's DOB: ______________________

Subscriber's Employer: ______________________ Employer's Phone: ______________________

Instructions: *(Check off to verify done)*

- ☐ Referral requested (Tricare, HealthSpring, Medicaid, etc.)
- ☐ Referring physician office to fax all records related to patient's condition
- ☐ Request office to send copy of driver's license and insurance card with records
- ☐ Patient to bring all medications or list of medications to appointment
- ☐ Patient to bring copay and/or $75 if self-pay
- ☐ New patient packet sent

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Staff Initials/Date/Time