

Plastic & Reconstructive Surgery

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Referral From: _____

Reason for referral: _____

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

Staff Initials/Date/Time