NEW PATIENT REFERRAL FORM
PLEASE FAX THIS COMPLETED FORM TO (256)304-5333

Thank you for your referral!

Please fax this completed form to 256.304.5333 along with copies of clinic notes, pertinent radiology studies and a copy of the patient's insurance card (front and back).

Patient name ______________________________ Preferred phone ______________

Address ____

City ______________________________ State __________ Zip ______________

DOB __________________ SSN ____________________ Gender ______________

Primary insurance ____

ID Number ______________________ Group number ______________________

Phone number ____________________ Additional phone number ____________________

Secondary insurance ____

ID Number ______________________ Group number ______________________

Phone number ____________________ Additional phone number ____________________

Referring Provider ______________________________ **NPI#** ______________

Address ____________________________ Phone ______________ Fax ______________

Primary care Provider (if different) ______________________________________

Phone ______________________ Fax ______________________

Please describe the referring complaint: ______________________________

Dx code: ____________ *Is a specific procedure requested?* ______________________

Additional Comments ____

1403 Old Water Works Road SW, Fort Payne AL 35968.
Phone: **256.646.7246** Fax: **256.304.5333**