Advanced Dermatology, PSC

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Patient Referral for Appointment

Please print patient information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt. # _____Zip Code: _____

Home Phone ( ) _____ Cell Phone or Alt. # ( ) _____

Date of Birth:_____/_____/_____ Sex: _____ Race: _____ Marital Status: □ S □M □D □W

SSN# _____
Required

Responsible Party & Insurance Information

Responsible Party: _____ SSN# _____ DOB:___/___/___

Insurance# 1 : _____ Policy# _____ Group # _____

Insurance #2: _____ Policy# _____Group# _____

****PLEASE ATTACH A COPY OF INSURANCE CARD(S)****

Referring Physician Information ****APPOINTMENT WILL NOT BE SCHEDULED UNLESS ALL INFORMATION COMPLETED**

Provider's Name: _____ Person submitting referral: _____

Referring Physician Office Name: _____

NPI# _____ Taxonomy # _____

Phone ( ) _____ Fax: ( ) _____

HISP address: _____(for meaningful use)

Appointment Reason: (Please be specific and indicate location)

_____

__ **Urgent** (i.e. suspicious or changing lesion, severe rash, pathology confirmed BCC/SCC,MM)
__ **Routine** (i.e. warts, eczema, acne, molluscum)
__ **Does the patient require handicap accommodations or 1st floor exam room**

Due to the large volume of referrals we receive daily, we will attempt to call the patient with the appointment; however, we ask that you also notify the patient. Thank you.
IF THE INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE ATTACH A COPY, APPOINTMENT WILL NOT BE SCHEDULED WITHOUT THE APPROVED REFERRAL.