



**ATLANTIC FOOT & ANKLE ASSOCIATES**

1890 LPGA Boulevard, Suite 230

Daytona Beach, FL 32117

386.374.3336 (Daytona Beach)

386.274-3660 (Daytona Beach fax)

www.AtlanticFootAndAnkle.com

**Referring Physician Form**

REFERRING PHYSICIAN: Date: \_\_\_\_\_

Name of Referring Physician: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ ext. \_\_\_\_\_

**PATIENT INFO:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE CARRIER INFO:**

Authorization # (if applicable) \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relation to Subscriber: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**REFERRAL INFORMATION:**

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

Reason for Referral/Diagnosis (ICD-9)

Check Box if Patient had:  MRI  X-Rays  EMG  CT Scan

Performed by:  Florida Hospital  Fish Memorial  Halifax Medical Center  Other