ATLANTIC FOOT & ANKLE ASSOCIATES
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Orange City, FL 32763
386.775.2281 (Orange City)
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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