ATLANTIC FOOT & ANKLE ASSOCIATES
21 Hospital Drive, Suite 150
Palm Coast, FL 32164
386.586.7373 (Palm Coast)
386.586.7346 (Palm Coast 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