ATLANTIC FOOT & ANKLE ASSOCIATES
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Port Orange, FL 32127
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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