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Digestive Health Specialists, P.A.

FOR CONSULTATION OR PROCEDURE REFERRAL FAX TO DHS AT 680-5654

PATIENT INFORMATION:

Patient Name: _____

Address _____

Social Security# _____ DOB _____

Phone #: Home _____ Cell _____ Work _____

INSURANCE: Please fax a copy of the front and back of insurance card.

Primary Carrier: _____ Policy Holder: Self Spouse Child

Policy # _____ Group# _____

Secondary Carrier: _____ Policy Holder: Self Spouse Child

Policy # _____ Group# _____

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name: _____

Office Phone: _____ Fax# _____

Consult for: COLON (diagnostic or screening) EGD Office Visit Other: _____

Note - Medicare and Blue Cross Healthy You covers screening colonoscopy. These patients do not require an office visit unless specified by the referring physician. Please indicate if this patient has screening benefits.

Diagnosis for referral _____

Special request: _____

FOR DIGESTIVE HEALTH USE ONLY	
APPT SCHEDULED FOR: _____	with Dr. _____
Date Patient Contacted: _____	Date Form Faxed to referring MD _____
Signature: _____	

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