SOUTHEAST SPINE CARE
& PAIN MANAGEMENT, INC.
Helping patients take control of pain.

7450 Skidaway Road ▪ Savannah, GA 31406
Phone 912.233.6811 Fax 912.544.0864

PLEASE SHARE:

__Patient Demographics
__Copy of Insurance Card (front & back)
__Last visit notes
__Last MRI/x-ray report
__Any additional notes pertaining to the referral

PATIENT REFERRAL

▢ **Ortelio Bosch, MD** ▢ **Lynne B. Williams, PA-C**

▢ evaluate & treat ▢ consult + procedure ▢ consult only ▢ procedure only
▢ STAT ▢ Soon ▢ Routine (no urgency)

PATIENT INFORMATION

Name _____ DOB ____/____/____
(first, middle, last)
Address _____

City _____ State _____ ZIP _____

▢ Male ▢ Female Social Sec # ____-____-____ Parent/Guardian _____

Patient's Day Phone ( ) _____

Mobile Phone ( ) _____ Email Address _____

REASON FOR REFERRAL/MEDICAL DIAGNOSIS/DIAGNOSIS CODE: _____

_____

PRIMARY INSURANCE (or attach insurance card) _____
Policy Holder's Name _____
Policy # _____
If no insurance, please check this box: ▢ uninsured

SECONDARY INSURANCE (or attach insurance card) _____
Policy Holder's Name _____
Policy # _____

REFERRING PHYSICIAN INFORMATION

Name _____ Referring Provider's NPI _____
Address _____ Phone ( ) _____
City _____ State _____ ZIP _____ Fax ( ) _____
Name of Contact Person _____

Fax completed form to us at 912/544-0864. *Thank you for your kind referral!*

INTEROFFICE USE: Date of Appointment _____ Time _____ AM/PM
Scheduled by _____ Date Scheduled _____
Referring MD notified of appointment? ▢ Yes ▢ No By _____