REQUEST FOR CONSULTATION

COASTAL RHEUMATOLOGY ASSOCIATES
5400 Waters Avenue ▪ Savannah, GA 31404
Phone 912/349-4227 ▪ Fax 912/349-4457
www.coastalrheumatology.com

Please be sure to send recent office notes with any pertinent lab/imaging reports
Fax along with this completed form to: 912/349-4227

PATIENT INFORMATION

Name_____ DOB_____/_____/_____
(first, middle, last)

Address _____

City_____State_____ZIP _____

Parent/Guardian _____

Patient's Day Phone ( ) _____ Mobile Phone ( ) _____

Email Address _____

PRIMARY INSURANCE (or attach insurance card) _____

Policy Holder's Name _____

Policy # _____

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 _____

REASON FOR REFERRAL _____

_____

Thank you for your kind referral. We appreciate the opportunity to provide service to your patient.

INTEROFFICE USE: Date of Appointment_____Time_____AM/PM

Scheduled by_____Date Scheduled _____

Referring MD notified of appointment? ▢ Yes ▢ No By _____