Consultation/ Referral Request
PLEASE PRINT
Fax to (517) 999-3931

URGENT
FIRST AVAILABLE
PATIENT WILL CALL

PATIENT INFORMATION

Name: _____ S.S. _____
Last First MI
Address: _____ DOB: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____
Cell Phone: (_____) _____
Work Phone: (_____) _____

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced

INSURANCE INFORMATION

We no longer accept new patients with Medicaid products

Primary Policy

Subscriber Name: _____ _____
Last First MI DOB
Insurance Company: _____
Contract #: _____ Group #: _____

Secondary Policy

Subscriber Name: _____ _____
Last First MI DOB
Insurance Company: _____
Contract #: _____ Group #: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____
Reason for Referral: _____