

PLEASE SCHEDULE APPOINTMENT WITH:

<input type="checkbox"/> Avery	<input type="checkbox"/> Davidson	<input type="checkbox"/> Reardon
<input type="checkbox"/> Barnes	<input type="checkbox"/> McDaniel	<input type="checkbox"/> Reynolds
<input type="checkbox"/> Bellam	<input type="checkbox"/> Nimmagadda	<input type="checkbox"/> Sarmad



Main Campus FAX (334) 260-2011
Prattville Campus FAX (334) 358-1207

- ASAP (within 72 hrs)
- 1st AVAILABLE
- 1-2 WEEKS

PATIENT INFORMATION:

Last: _____ First: _____ MI: _____

DOB: _____ SS#: _____ Sex: M F Race: _____

Address _____
 Street City St Zip Phone/Alt. Phone

Referring MD: _____ Phone #: _____ Fax #: _____

NPI #: _____ Address: _____

Diagnosis/Reason for Referral: _____

PLEASE FAX PATIENT DEMOGRAPHICS WITH INSURANCE INFORMATION

Primary:

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> BCBSAL
<input type="checkbox"/> BCBS Out of State	<input type="checkbox"/> BCBSAL BEG (Referral Required)	<input type="checkbox"/> TriCare (Referral Required)	<input type="checkbox"/> Patient 1 st (Referral Required)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Self-Pay – No Insurance		

Secondary:

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> BCBSAL
<input type="checkbox"/> BCBS Out of State	<input type="checkbox"/> BCBSAL BEG	<input type="checkbox"/> TriCare	<input type="checkbox"/> Patient 1 st

PLEASE SEND RECORDS WITH REFERRAL FOR ALL DIAGNOSES

➤ ➤ Records are required before appointment can be scheduled < <

<input checked="" type="checkbox"/> Last 3 Office Notes (last 3 visits)	<input checked="" type="checkbox"/> Lab Reports (1-2 years)
<input checked="" type="checkbox"/> Pathology (surgical, genetic, stains)	<input checked="" type="checkbox"/> Colonoscopy/EGD Reports with Pathology
<input checked="" type="checkbox"/> Operative and Procedure Notes	<input checked="" type="checkbox"/> Imaging (Mammogram, PET, CT, MRI, US, Nuclear Medicine, Bone Density) ➤ Send imaging studies on CD with patient

Appointment Date: _____ Time: _____ AM PM MCC MD: _____

PATIENT SHOULD ARRIVE 1 HOUR PRIOR TO APPOINTMENT TIME

*** We ask that you notify your patient of the date and time of the appointment ***
 ** Instruct patient to bring driver's license and all insurance cards to appointment **

FAX THIS FORM AND RECORDS PERTAINING TO APPROPRIATE SCHEDULING DEPARTMENT:

(334) 260-2011 Montgomery	(334) 358-1207 Prattville
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