

Central California Ear, Nose & Throat Medical Group
Phone: (559) 432-3303 Referral Fax: (559) 432-6195
PATIENT REFERRAL FORM – FRESNO OFFICE

Instructions:

1. Please print the most current information for the patient as requested below. Please be sure to complete all sections.
2. Fax this form to our referral fax line: **(559) 432-6195**.
3. Within 24 hours, we will complete the appointment section at the bottom of this form and fax it back to you.
4. Upon your receipt of our form, please notify the patient of the appointment date and time.
(Note: we do not contact the patient at the time the appointment is made)

*** **Please Print** ***

Patient Information:

Patient's Full Name: (First) _____ (Last) _____

Patient's Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ (____) Cell Phone (____) _____

Date of Birth _____ Social Security # _____

Marital Status: Single Married Other Sex: Male Female

Emergency Contact/Message: Full Name _____ Phone # _____

Insurance Information:

Primary Insurance Coverage

Secondary Insurance Coverage

Insurance Company _____

Type HMO PPO HMO Sante HMO PPO HMO Sante

Physician Information:

Referring Physician M.D. _____ NPI# _____ Fax #: _____

(please list Supervising Physician for P.A or N.P.)

Diagnosis Description (not code): _____ D.O.I. _____

CCENT Physician Requested: _____

Section to be completed by CCENT

Appointment Information:

CCENT Physician: _____ Physician Assistant: _____

Appointment Date: _____ Time: _____

Scheduler: _____ Date: _____

Note to Referring Physician's Office:

Please Notify Patient of Appointment Date & Time As Soon As Possible.

Please send us your records pertaining to this diagnosis.

If patient has had diagnostic tests, please have them bring films/scans with them.

(This form may be downloaded from ccent.com/refer)