Central California Ear, Nose & Throat Medical Group
Phone: (559) 636-1800 Referral Fax: (559) 636-1881
PATIENT REFERRAL FORM – VISALIA 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) 636-1881.**
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 ___PPO

Physician Information:

Referring Physician M.D. _____ NPI# _____ Fax #:_____
(please no 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: _____

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 along with a copy of the patient's insurance card.

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

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