PATIENT REFERRAL

Julie Rubin McGaughey, L.P.C.
5 Oglethorpe Professional Blvd.
Suite 220
Savannah, GA 31406

Phone 912/658-8169 ▪ Fax 678/658-9029
www.atlanticcoastaltherapy.com

PLEASE FAX COMPLETED FORMS TO 678/658-9029

PATIENT INFORMATION

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

Address _____

City_____State_____ZIP _____

Parent/Guardian _____

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

Patient's Email Address _____

PRIMARY INSURANCE _____

Policy Holder's Name _____

Policy # _____

SECONDARY INSURANCE _____

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. I appreciate the opportunity to provide service to your patient.

INTEROFFICE USE: Date of Appointment_____Time_____AM/PM

Scheduled by_____Date Scheduled _____

Referring notified of appointment? ▢ Yes ▢ No By _____