

NORTHLAND PSYCHIATRIC SPECIALISTS, LLC

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PHYSICIAN REFERRAL FORM -NEW PATIENT- (PLEASE PRINT)

Date: _____

REFERRING PHYSICIAN: _____

Set appointment with: _____ 1st Available _____ Dr. Hill _____ Dr. Spurlock _____ Dr. Meyer

Contact Name at office: _____ Phone number: _____

Contact: ___patient/guardian at _____ or ___referring physician's office to schedule this appointment.

Reason for referral: _____

Current Meds: _____

Drug Allergies: _____

Is patient disabled: _____ Comments or concerns: _____

PATIENT NAME: _____

Date of Birth: _____ Sex: _____ Female _____ Male

Phone numbers: Home: _____ Cell: _____ Work: _____

Home Address: _____ City: _____ State: _____ Zip: _____

If patient is under 18 or disabled whom should we contact: _____

INSURANCE COMPANY: _____

ID #: _____ Group #: _____ Main Phone: _____

Subscriber Name: _____ Social Security #: _____

Subscriber Date of Birth: _____ Employer Name: _____

Patients relationship to subscriber: ___self ___spouse ___parent ___other (explain) _____

SECONDARY INSURANCE: _____

ID #: _____ Group #: _____ Main Phone: _____

Subscriber Name: _____ Social Security #: _____

Subscriber Date of Birth: _____ Employer Name: _____

Patients relationship to subscriber: ___self ___spouse ___parent ___other (explain) _____

We will contact you to schedule an appointment when eligibility and benefits have been verified with your insurance.