ORTHOPEDIC CENTER

NEW PATIENT REFERRAL FORM

PHONE (323) 361-2142 FAX (323) 361-3112

PATIENT'S INFORMATION **Date:**_______________ **Time:**_______________

Caller's Name: ____ Relationship: _______________

Patient Last Name: ___________________ First Name: _______________ * DOB: _____________

*Address: _________________________________ City: _______________ Zip Code: _____________

*Primary phone: __________________________ Secondary Phone: ___________________________

PARENT OR GUARDIAN INFORMATION

Name: __________________________ Relationship: ____________________

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*Diagnosis: _________________________________ * Requested Physician: _____________________

*Date of injury: ________________ *Did the child have recent x-ray (Date): _____________________

Was another orthopaedist seen for this problem? YES / NO Who/When: ______________________

*Existing medical conditions: ____

Does the patient see any other non-PCPs: ____

*Date of Surgery: ________________________

***Referring Physician**: _____________________ ***Primary Physician:**________________________

Hospital/Address: _________________________ Hospital/Address: ___________________________

City:_____________________________________ City: _____________________________________

Phone: ___________________________________ Phone: ____________________________________

FINANCIAL INFORMATION (Authorization/Referral must be attached)

PRIMARY INSURANCE

Insurance Name: ____

☐ Commercial ☐ HMO ☐ PPO ☐ Self Pay

Authorization Number: _______________________________ Group Number: __________________

Guarantor DOB: __________________________________

OFFICE USE ONLY:

MRN#: ______________________ Appointment Date: ______________ Time: ______________

Assigned Physician(s): ______________________________ * ACR Initials: ______________

**** MUST BE FILLED OUT BEFORE GIVING TO NURSES)**