NEW PATIENT REFERRAL FORM

Gray Spine, PLLC | 201 S A Street, Pensacola, FL 32502
Phone: 850-934-7545 | Fax: 850-468-4358 | appointment@grayspine.com

Referral Information

Date: _____

Referring Provider: _____

Phone: (_____)_____ Fax: (_____)_____

Referred to: Dr. William Gray

Patient Demographics

Name: _____

Date of Birth: _____ SSN: _____ Gender: ■ Male ■ Female

Phone: (_____)_____ Cell: (_____)_____

Email: _____

Address: _____

Insurance Information

Insurance: _____ Policy Number: _____

Group Number: _____ Circle One: ■ PPO ■ HMO

Authorization Number: _____ Expiration: _____

Address: _____

If workers comp or MVA – DOI/DOA: _____ Adjuster's Name: _____

Phone: (_____)_____ Fax: (_____)_____

Secondary Insurance: _____ Policy Number: _____

Address: _____

Clinical Information

Diagnosis / Reason for Referral: _____

Has the patient had any of the following? ■ X-Ray ■ MRI ■ CT ■ EMG Location: _____

Please Attach (if available):

- ■ **Office notes** ■ **Radiology/diagnostic reports** ■ **Previous pain management records**
- ■ **Copy of insurance card** ■ **Copy of photo ID** ■ **Insurance authorization**
- ■ **Physical therapy records** ■ **Chiropractic records**

Please email completed form and attachments to appointment@grayspine.com

Appointment Date & Time with Dr. Gray: _____