

Consultation Request Form

The purpose of this form is to assist the provider with knowing whether this visit is to be billed as a consultation, new patient visit or established patient visit.

Patient name:	Address:
Date of birth:	
Phone number (h):	Phone number (w):
Patient Insurance Information:	
Needs to be seen: <input type="checkbox"/> ASAP <input type="checkbox"/> within 1 week <input type="checkbox"/> Other, please explain:	
For: <input type="checkbox"/> Evaluation <input type="checkbox"/> Treatment <input type="checkbox"/> Evaluation and Treatment	
Patient Preliminary Diagnosis, Symptoms or Signs: <i>[This section should also be used to list any tests or procedures performed for this patient presenting problems.]</i>	
Please communicate findings to me by: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> E-mail	
Requesting Physician/Provider name and NPI number:	Address:
Phone:	
Fax:	E-mail: