

APPOINTMENT SCHEDULING

352-331-8902 fax 352-331-5591

PATIENT INFORMATION

Fax Referral Form

Date _____ Date of Birth _____ Social Security Number _____

Last Name (please print) _____ First Name _____ Male or Female _____

Home Phone Number _____ Cell Phone Number _____

Primary Insurance Plan and Policy Number _____

Secondary Insurance Plan and Policy Number _____

PATIENT PREFERENCES

My patient would prefer to be seen by:

- Thomas R. Beers, M.D.
- Gabu Bhardwaj, M.D.
- Payam Chini, M.D.
- Dennis P. Collins, M.D.
- Jason D. Hallman, M.D.
- Ronald C. Lee, M.D.
- John R. Leibach, M.D.
- Daniel G. Maico, M.D.
- Enrique G. Molina, M.D.
- Shea O. Ross, M.D.
- Charles A. Sninsky, M.D.
- Renata Wajsman, M.D.

REFERRAL

- THIS REFERRAL IS URGENT!**
- Consultation**

Reason for referral: _____

- Patients pertinent medical records are included with this fax**

Services Provided by DDA:

- Colonoscopy
- Upper Endoscopy
- Fiberoptic Sigmoidoscopy
- Capsule Endoscopy
- EUS
- ERCP
- Hepatitis Treatment
- Infusion Therapy
- Hemorrhoid Banding
- Interstim Treatment

REFERRING PHYSICIAN

Practice Name _____ Physician Name _____

Practice Address _____

Practice Phone Number _____ Practice Fax Number _____

Office Contact (In case we have any questions) _____

Invite your patients to visit us at

GainesvilleGI.com

Where your patients can complete information for their upcoming appointment.

DDA USE ONLY

Date Received: _____

1st _____ Entered by: _____

2nd _____ Patient # _____

3rd _____ Appt. Date/Time: _____

Thank you!

Thank you for trusting us with the care of your patients. We will notify your office when this appointment is scheduled