Date:_________ *All Asteriks **_must_** be completed

Initials:________

Palmetto Orthopaedic & Sports Medicine

Dr. Drakeford
Ron Chappell, PA-C

- Referral From Dr.______________
- New Patient:
- Established: chart#_____________
- Work In:
- Patient Self referred

Appointment Date:_____________________

***Person making Referral:____Phone:_____________________**

***Patient Name:___________________________________DOB:________________Age:____________________**

***Patient Address:____**

***Phone:__________________Cell#___________________Work______________________________________**

***Person to Notify:____**

Guardian: (if a child)________________Guardian:DOB:________SS#____________________________________

***Reason for visit:____**

***MRI:_________________________EMG__________________CT Scan__________________________________**

***Facility of Test_________________ Test Date____________ Obtained Results___________________________**

****Auto Accident or Other Accident: Y N Date of accident:__________ Workers Comp:______ Seen in the ER:____***

****Were X-rays made: Yes No Was patient admitted to the hospital:_______ Where/Date:_________________***

*** Lawyer Involved Y N * Self Pay: $250.00 must be paid & Questionnaire must be filled out & attached***

***Primary Ins:_____________PolicyHolder_____________DOB_________ID#____________SS#_______________**

***Secondary Ins:___________Policy Holder_____________DOB_________ID#____________SS#______________**

***Workers Comp Authorization#:_________________ Employers Name:__________________________________**

***Workers Comp Carrier:_______________________ Contact:____**

***Phone:_______________ Fax:_________________ Billing address:______________________________________**

Revised 5/8/2013