South Texas Bone & Joint

601 Texan Trail, Suite 300 Corpus Christi, Texas 78411 Phone: 361-854-0811

REFERRAL FAX FORM

Date:

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Physician: Seger (Circle One) 806-5031		eckenridge Thomas 5-5032 561-0624	Borkowski 806-5037	Grosser 806-5038	Klimisch 561-0626	Montgomery P.AC 561-0628 or FNP-C
Patient Name:					_ DOB:_	
]	First Name	MI	Last Nam	e		
Address:		City / State / Zip:			_ SSN#: _	
Home Phone #:		Work Phone #:			Cell:	
□ New Patient E	valuation Only	□ New Patie	nt Evaluate &	&Treat		llow up office visit
Chief Complaint: _						
Diagnosis:						
		ICD-9(Diagnosis Code)				
Referring Physician:		Contact Name for Call Back:				
Referring Physician Phone #:			Fax #:			
Medicare	PPO	HMO P	POS (Other		
Insurance Carrier:			Referral #:			
		ll appointments requirin Iuled. We appreciate yo				re <u>NOT</u> received 24 hrs matter.
Special Instruction	ns:					
For STBJ office	e use only:					
Monday	Tuesday	Wednesday	Thursday		Friday	
Appointment date:		Time:	Scheduled with:			
☐ Call Office ☐ Call Patient		nt 🗆 Fax:	☐ Patient to make appointment			

Please fax copy of this form, front & back of insurance card, driver's license, referral authorization sheet, and any applicable medical records. Patient should bring MRI and/or plain films to consult visit. This form may be used as an option to calling to schedule an appointment. **NOT FOR EMERGENCY/FRACTURE CARE APPOINTMENTS.**