CAPITAL RHEUMATOLOGY

Priyank Chaudhary, MD
Phone: (919) 341-3603
Fax: (919) 341-3610
www.CapitalRheum.com

Request for Consultation

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: ______________________ DOB: __________ Race: __________ Gender: □M □F

Address: ______________________ City/State/ZIP: ______________________

Phone (Please circle preferred number) Home: __________ Cell: __________ Work: __________

Does patient need an interpreter? □Y □N If yes, please specify language: ______________________

INSURANCE INFORMATION

Insurance Name: ______________________

Policyholder's Name: ______________________ Policyholder's DOB: __________

Insurance Phone: __________ Policy Number: __________ Group Number: __________

Medicaid Authorization NPI: ______________________ Authorized Number of Visits: __________

REFERRAL INFORMATION

□Routine □Urgent Reason for Referral: ______________________

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REFERRING PROVIDER INFORMATION

Name: ______________________ Practice Name: ______________________

Address: ______________________ City/State/ZIP: ______________________

Phone: ______________________ Fax: ______________________

Form Completed By: ______________________ Date: ______________________

Please send recent lab results, radiology reports, and notes of the referring provider along with any other pertinent information.

Thank you for referring your patient to Capital Rheumatology!