Referral Form

NEUROLOGY CONSULTANTS
HUNTSVILLE

Fax patient records *and* this completed form to:

256-429-9021

First available appointment date and time will be faxed to your office within **3 business days**.

NEUROLOGISTS
Amit Arora, M.D.
Aruna Arora, M.D. (EMG/NCS ONLY)
Kasha Benton, M.D.
Ian McGuinness, M.D.
Carolina Parker, M.D.
Jay van Gerpen, M.D.
David White, M.D.

Date: _____

PATIENT INFORMATION

Patient's Name: (FIRST) _____ (MI) _____ (LAST) _____

Patient's D.O.B.: _____/_____/_____

Patient's Address: _____

_____

Daytime Phone #: _____ Cell #: _____ Evening Phone #: _____

PATIENT INSURANCE INFORMATION (Please fax insurance card**)**

Primary Insurance: _____

Policy#: _____ Group#: _____

Secondary Insurance: _____

Policy#: _____ Group#: _____

Does patient's insurance require a referral? (check) Yes _____ No _____

Reason for referral/problem: _____

_____

REFERRING PHYSICIAN

Physician's Name:_____NPI#_____

Name of Practice: _____

Physician's Office #:_____ Physician's Fax #: _____