PIEDMONT PSYCHIATRIC SERVICES
Piedmontpsychiatric.com

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NEW PATIENT REFERRAL FORM

DATE: ____/____/____ PHYSICIAN REQUESTED: _____

REFERRED BY:_____ OFFICE CONTACT: _____

REFERRAL EMAIL: _____ BACKLINE#: _____

ADDRESS: _____ FAX#: _____

PLEASE NOTE THAT WE <u>DO NOT</u> ACCEPT PATIENTS THAT ARE ELIGIBLE FOR <u>MEDICAID</u> OR HAVE THIS AS PRIMARY OR SECONDARY INSURANCE.

PATIENT INFORMATION (We will contact the patient to schedule appointment)

NAME _____ DOB ____/____/____ SSN _____

Parent Name (if minor) _____ Work Place _____

HOME ADDRESS_____

CITY _____ STATE _____ ZIP _____

HOME #(_____) _____ CELL #(_____) _____

PRIMARY INS: _____ **SECONDARY INS:** _____

CHIEF COMPLAINT: _____

_____

PLEASE FAX COMPLETED FORM WITH MEDICAL RECORD AND INSURANCE CARDS TO 864-676-9432

ANY QUESTIONS, PLEASE CONTACT OUR REFERRAL COORDINATOR AT 864-676-9211 Ext. 143 or ssantay@piedmontpsych.com