Georgia PAIN and SPINE Care

FAX REFERRAL TO: (678) 854-9937

EMAIL REFERRAL TO: Referrals@gapaincare.com

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: ___/___/_____ SSN: ____-____-_____ Sex: ☐ Male ☐ Female

Primary Phone: _____ Mobile: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name: _____

Phone Number: _____ Fax Number: _____

The above patient has been referred for (Diagnosis): _____

☐ Medication Management ☐ Transfer of Care ☐ Request Consultation for: _____

☐ Diagnostic Procedure (please list): _____

☐ Evaluation for Clinical Trial (Better Health Clinical Research) ☐ Other: _____

INSURANCE INFORMATION

☐ **Primary Insurance**: _____ Policy #: _____ Group #:_____

☐ **Worker's Compensation Patients**: Adjuster: _____ Phone: _____

Fax: _____Claim #: _____ Date of Injury: ___/___/_____

☐ **Personal Injury Patients**: Attorney: _____ Phone Number: _____

PLEASE BE SURE TO INCLUDE THE FOLLOWING INFORMATION

- **Medical records relating to pain**
- **Copy of Insurance cards (front and back)**
- **Insurance Referral (if necessary)**

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AS 770.252.7557

Thank you!