

PULMONOLOGY



**Charleston Area
Medical Center**

 **Vandalia Health**

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DEMOGRAPHICS

Patient Name: _____ DOB: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Primary Insurance: _____

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ NPI: _____

Mailing Address: _____

Phone: _____ Fax: _____

REASON FOR REFERRAL: _____

Records attached (*pertaining to reason appointment needed-labs, notes, imaging reports*)

Information in Cerner (*no need to send records-can send referral internal*)

APPOINTMENT INFORMATION

Appointment Date/Time: _____ with: _____

Please notify patient of appointment date/time.

**Clinic in Teays Valley and Charleston*