

RHEUMATOLOGY



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.