

Date: _____

PATIENT REFERRAL FORM

Laura Tamburin, MD ___ Tonia Ruddock, MD ___ Dana Culpepper, PA-C ___ Kelli Heer, PA-C ___

First Available ___

Referring Provider: _____ City/State: _____

Phone: _____ Fax: _____

Office Contact: _____

PATIENT INFORMATION

Patient Name : _____ Date Of Birth: _____

SSN: _____ Phone: _____

Address: _____ City, State, Zip: _____

Email: _____

INSURANCE INFORMATION

Insurance: _____ Member ID: _____

Group #: _____ Name of Insured: _____ DOB of Insured: _____

2nd Insurance: _____ Member ID: _____

Group #: _____ Name of Insured: _____ DOB of Insured: _____

Reason for Referral: _____

Please complete this form in its entirety and return it with **related medical records** via direct mail to jpenley@dermdothan.emadirect.md or fax to 334-218-0382. A scheduler will contact the patient regarding the appointment. For questions regarding referrals, you may speak with our referral specialist at 334-828-7546, extension # 1.

Thank you for choosing Dermatology & Skin Health of Dothan!