PULMONOLOGY

Charleston Area Medical Center

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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:____

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- ❑ 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*

39680-G24