Spine LLC
1090 Beecher Crossing North
Suite A
Gahanna, OH 43230

PATIENT REFERRAL TO SPINE LLC

Date:______________________

Thank you for referring your patient to our office. Please complete the information sheet and fax back to our office along with office notes, imaging and other patient records to 614-392-5339.

Referring Physician Information

First Name: ____________________________ Last Name: ____________________________

Degree: ________________________________

Office Address: ____

____

Phone: ________________________________ Fax: __________________________________

NPI # ____

Patient Information

First Name: ____________________________ Last Name: ____________________________

Date of Birth: _____/_________/__________

Social Security Number: ____

Male _____ Female ______

Phone: ____

Alternate Phone: __________________________________

Patient's Address: ____

____

City: __________________________ State: ____________________ Zip: __________________

Spine LLC
1090 Beecher Crossing North
Suite A
Gahanna, OH 43230

Insurance Information

Insurance: ______________________________

Name of Card Holder: ______________________________

Card Holder's Date of Birth: ______/______/________

Insurance Provider's Phone # ______________________

Policy # ______________________

Group Claims Address: ______________________________

____

City: ______________ State: ______________ Zip: __________

Clinical Information

Reason for Referral: ______________________________

Diagnosis: ______________________________

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Thank You

Dr. Nikesh Batra

Our office will contact your patient within 24 hours to schedule an appointment.