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CONTACT PERSON: Jessica

PATIENT REFERRAL FORM

Referring Physician: _____ Phone: _____
Contact Person: _____ Fax: _____

Patient Name: _____ SSN: _____
DOB: _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Employer: _____

Insurance Company: _____ Phone: _____
Date called: _____ Person spoke With: _____
ID#: _____ Policy Holder: _____
Auth#: _____ #of visits: _____ EXP: _____
DOB: _____ SSN: _____ Patient
Diagnosis: _____ ICD-9: _____
Procedure: _____ CPT Code: _____

PLEASE FILL IN ALL INFORMATION. **ATTACH ALL PERTINENT MEDICAL RECORDS, COPY OF INSURANCE CARD, AND AUTHORIZATION.** WE WILL CALL THE PATIENT TO SCHEDULE. YOU WILL BE NOTIFIED OF APPOINTMENT WHEN SCHEDULED.

DATE PROCEDURE SCHEDULED: _____ TIME: _____

Thank you for your referral©