



NEW Patient Contact Information
Ft Walton Beach/Destin/Milton/Crestview/
Panama City Beach/Pensacola
info@dynamicpainandwellness.com
FAX (877) 413-5104
PHONE (850) 226-6801

NEW PATIENT REFERRAL FORM

A complete referral form will ensure efficient scheduling for your patient.

DATE: _____
REFERRING DR: _____ NPI: _____
PHONE: (____) _____ FAX: (____) _____
ADDRESS: _____

PATIENT INFORMATION

NAME: _____
DOB: _____ SSN: _____ GENDER M F
PHONE: (____) _____ ALT PHONE: (____) _____
ADDRESS: _____
DIAGNOSIS CODE and DESCRIPTION: _____

INSURANCE INFORMATION

CARRIER: _____ PPO HMO
SUBSCRIBER NUMBER: _____
REFERRAL/AUTHORIZATION NUMBER: _____
DATES OF SERVICE APPROVED: _____ - _____
CPT CODES APPROVED: _____ 99204 AND 99213

SECONDARY INSURANCE INFORMATION

CARRIER: _____ PPO HMO
SUBSCRIBER NUMBER: _____

ADDITIONAL INFORMATION

IS THIS TREATMENT RELATED TO A MOTOR VEHICLE ACCIDENT? YES NO
IS THIS TREATMENT RELATED TO A WORKER'S COMP CLAIM? YES NO
IS THIS CLAIM STILL OPEN? YES NO