Lansing SURGICAL ASSOCIATES

Office of
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NEW PATIENT REQUEST

Patient Name:_____ Date of Birth:_____
(First, M.I. Last)

Parent/Guardian for minor child:_____

Address:_____
(Number, Street, City and Zip Code)

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Insurance: (PLEASE INCLUDE COPY OF INSURANCE CARD) _____

Workers Compensation Yes ____ No _____ Date of Injury _____ Claim # _____
***Workers Compensation requires a prior authorization before an appointment is scheduled. Please include written authorization with claim number, adjustor's name and contact information. ***

Referring Physician: _____
(NP & PA's please INCLUDE supervising MD or DO)

Phone: _____ Fax: _____ Contact Person:_____

Reason for referral:_____

Any previous testing: Yes _____ No _____ ****Please include all test results and pertinent medical records, including current medication list and last office note.**

PATIENT MUST BRING ALL IMAGING FILMS (X-RAYS, MRI/CT), PICTURE ID AND INSURANCE CARDS TO HIS/HER APPOINTMENT.

Patient needs to be seen: Urgent (1-2 days) ASAP (1 week) Next Available

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Appointment Scheduled On: Date: _____ Time: _____ am/pm