CONSULTATION REQUEST

Patient Information

Name: ______________________________Phone: ____________________

Address: ____________________________DOB: ____________________

City: __________________Zip: __________SSN#:____________________

Email Address: ____

Emergency Contact / Relationship:_____________________________________

Emergency Contact Phone#: ______________________________________

Employer: ____

Primary Ins:_______________________ID/Group#:____________________

Secondary Ins: ____________________ ID/Group#:____________________

Does patient have special needs (i.e. wheelchair / mental incapacity): Y N

If yes, please explain:____

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Referring Doctor Information RETURN FAX:_____________________

Name: _________________________ Phone:______________________

Address: ____

This patient is being referred to <u>C. JOSEPH BECK, MD - 2700 E. 30th Ave., Hutchinson, KS</u>

Date of patient's last exam: ________________

Referral Diagnosis OD: ____

Referral Diagnosis OS: ____

Completed By: ________________________

<u>CPE Office Use Only</u>

Date / Time of appt: ________________ **CPE Acct#** ____________________

Please fax completed consultation form, copies of insurance cards, any pertinent records including diagnosis and imaging/testing to (316)712.4987

Updated 06.04.2021