Masdon ENT & Facial Plastic Surgery
Masdon ENT Hearing Aids
FYZICAL Therapy & Balance Centers

DR. JAMES L. MASDON, M.D. / DR. HANNAH NIXON, AU.D. / RHONDA KILPATRICK, PT

Please complete this form and fax to us along with patient's records. We will call the patient to set up an appointment and we will fax this form back to you with the appointment date and time for your records.

Boaz Fax - (256) 840-4584

REFERRAL FORM

Date: _____

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____

Referring Physician: _____ NPI Number: _____

Office Phone: _____ Fax Number: _____

REASON FOR VISIT: _____

Does insurance require a referral? Yes No Referral Authorization Number: _____

Primary Insurance: _____

Contract Number: _____ Group Number: _____
Name of Insured: _____ Date of Birth: _____

Secondary Insurance _____

Contract Number: _____ Group Number: _____

Name of Insured: _____ Date of Birth: _____

PLEASE ATTACH:

- **REFERRAL IF REQUIRED BY INSURANCE**
- **MOST RECENT OFFICE VISIT AND ANY RELEVENT TESTING PERTAINING TO THEIR DIAGNOSIS.**

APPOINTMENT DATE & TIME: _____

Thank you for your referral.

Masdon ENT & Facial Plastic Surgery/ Masdon ENT Hearing Aids / Fyzical Boaz
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