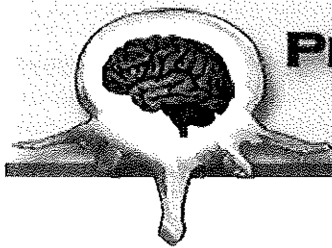

PIEDMONT SPINE
& NEUROSURGICAL GROUP, PA

CONSULTATION REQUEST
GREENVILLE OFFICE
PHONE: 864-220-4263 FAX: 864-220-5836

REQUESTED BY: DR. ____ DATE:___/___/___

UPIN# ____________________ NPI#_____________ CALLER:_________
THESE NUMBERS ARE REQUIRED BEFORE APPT CAN BE MADE

ADDRESS: ____________________ CITY:______________ ZIP: ______

PHONE: (_____) _____- _____ FAX (____) ______- ______

PATIENT INFORMATION

FULL NAME: ____ DOB: ___/___/___
FIRST MIDDLE LAST

ADDRESS: ____
#STREET CITY STATE ZIP

HOME# (____) ______-________ WORK# (____) _____-_____ CELL# (____) _____-_____

SOCIAL SECURITY NUMBER: ________- ________-_______ EMAIL ADDRESS: ________________________

DIAGNOSIS: ____

SYMPTOMS: ____

ONSET OF SYMPTOMS: ______________________________ DATE OF INJURY:____________

IS THIS THE RESULT OF A WORK INJURY OR MOTOR VEHICLE ACCIDENT: YES / NO
(We do not file with motor vehicle insurance.)

TYPE OF DIAGNOSTIC PROCEDURES:________________________ LOCATION:______________

TREATMENT: (Example: physical therapy, pain management.) Please list: ________________________

HAS THE PATIENT HAD SURGERY FOR THIS CONDITION BEFORE? YES / NO; WHEN? _____________
BY WHOM? ________________________ LOCATION: ______________________________

INSURANCE COMPANY: ________________________ POLICY#: ________________________

PLEASE SPECIFY: DR. BUCCI / DR. MINA / FIRST AVAILABLE

PLEASE FAX THE FOLLOWING TO (864) 220-5836

- COPY OF INSURANCE CARDS, FRONT AND BACK. (PLEASE OBTAIN REFERRAL AUTHORIZATION IF NEEDED
- TREATMENT NOTES
- DIAGNOSTIC REPORTS
- PLEASE HAVE PATIENT BRING FILMS/DISC TO APPT. THE PATIENT CANNOT BE SEEN WITHOUT IT.

WE WILL CONTACT THE PATIENT WITH THE APPOINTMENT TIME ONCE THE ABOVE INFORMATION HAS BEEN RECEIVED AND REVIEWED. PLEASE NOTE THAT SOME REFERRALS REQUIRE THE DOCTORS' REVIEW OR PRIOR AUTHORIZATION AND MAY TAKE LONGER TO SCHEDULE.
FOR PNG USE ONLY:

SCHEDULED BY: ________________ APPT DATE: ___/___/___ APPT TIME ___:___ AM/PM
NOTES: