



BAY REGION

PLASTIC AND RECONSTRUCTIVE SURGERY
3175 W. PROFESSIONAL DRIVE
BAY CITY, MI 48706
PHONE 989-316-4110 FAX 989-316-4115

NEW PATIENT REFERRAL FORM

REFERRING OFFICE TO COMPLETE AND FAX:989-316-4115

Form fields for patient information: TODAY'S DATE, PATIENT NAME, D.O.B., ADDRESS, CITY, STATE, ZIP, HOME PHONE, CELL/WORK, REFERRING PROVIDER, PHONE, FAX, REASON FOR REFERRAL, PRIMARY INSURANCE, PATIENT ID#, GRP#, EFFECTIVE DATE, SECONDARY INSURANCE, PATIENT ID#, GRP#, EFFECTIVE DATE.

Please fax this form back to us with labs, tests, notes, including other provider notes records and any information pertaining to this referral. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

1. Does patient's insurance require a referral and/or insurance authorization?
Referral# and/or copy of referral

Dr. Yonick's Office Use Only

Form fields for office use: Appointment Date, Time, Patient notification: Date, Staff Initials, Referring provider notified: Date, New patient packet mailed on: Date, Staff Initials, Insurance verified: Yes, No, Method.