Pediatric Gastroenterology of Charleston, PLLC

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Phone: (304) 400-4626; Fax: (304)400-4634

Reason for Consult

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Patient Demographics

Patient Name: ………………………………………………………………………… **DOB:** ……………………………………………………………

Parent/Guardian name: ………

Street address: ……

City: ……………………………………………… **State:** …………… **Zip:** …………………… **Home phone:** ……………………………………

Work Phone: ………………………………………**Ext:** ……………………. **Cell Phones:** …………………………………………………………

Insurance Information

Primary Insurance: ………………………………………………………………… **Check one: PPO**……. **Managed Care**………………………

ID# ……………………………………………………………………………………………**WV Med#**……………………………………………………

Secondary insurance: ……………………………………………………………………**Check one: PPO**…………**Managed Care**……………………..

ID#……………………………………………………………………………………………… **WV Med#**……………………………………………………..

Cardholder's Name and DOB (if different form patient: …………………………………………………………………………………….

Referring Physician Information

Physician Name: …………………………………………………………………… **NPI#** ………………………………………………………………

Address: ………………………………………………………………… **City:** ……………………………**State:** …………… **Zip**: ……………………………

Office Contact: ……………………………………… **Phone:** ……………………………………………… F**ax:** ……………………………………………

Appointment in our office scheduled for: / / at AM / PM

Please send all records pertaining to the reason of the referral with copies of all insurance cards by fax to our office.

If insurance requires prior authorization, please send it prior to appointment