

NEW PATIENT REFERRAL FORM

*Patient's Name: _____

*Patient's DOB: _____ *Insurance: _____

*Mailing Address: _____

*City: _____ *State: _____ *Zip: _____

*Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____

*Referring MD: _____ *Fax: _____

*Reason for Referral: _____

Please fax this referral form along with the documents listed below to
(252) 222-5705 or e-mail to info@BeachDoctor.com.

- most recent office notes,
- all pertinent labs, and
- all pertinent x-ray reports
- Copy of current insurance card (if possible)

We will schedule the first available new patient appointment and relay the appointment time back to your office. Thank you.

For Dr. Lucas's Office Only:

APPOINTMENT DAY: _____

APPOINTMENT TIME: _____