DEMERA
ALLERGY ASTHMA & ENT CENTER

PATIENT REFERRAL

Instructions:

1. Please print the most current information for the patient as requested below or attach most current face sheet. Be sure to complete all sections.
2. Fax in this form to our office: (559) 431-0301
3. **We are unable to accept any incomplete referrals. Please fill out all required information, patients full name, date of birth, address, phone numbers, correct/all insurance information, if HMO plan- authorization(s) for appointment, guarantor's info (if minor), all referring office information and treatment needed. Clear copies of insurance card(s) and photo ID are required to process your patient's referral.**

Patient Information

Patient's Full Name: (First) _____ (Last)_____

Patient's Mailing Address_ _____

City_____ State _____ Zip_____

Home Phone (____) _____ Work Phone (____) _____ Cell (____)_____

Date of Birth _____ / _____ / _____ Social Security # _____ - _____ -_____

Marital Status: ☐ Single ☐ Married ☐ Other Sex: ☐ Male ☐ Female

Emergency Contact: Full Name _____ Phone: (____)_____

Insurance Information **Primary Insurance Coverage** **Secondary Insurance Coverage**

Insurance Company: _____ _____

Policy Number: _____ _____

Physician Information

Referring M.D. _____ NPI# _____ Fax #_ _____

Diagnosis Description (not code)_____

_____

☐ Richard S. DeMera M.D. - Office: ☐ Fresno ☐ Visalia

☐ Kristin Leonard, FNP-BC (ENT- Affiliated w/ Dr. Sohrab Sohrabi)

☐ Jennifer Ruch, CPNP

☐ Jessica Halstead, FNP-C

☐ Maelyn McCarty MA, CCC-SLP

Note to Reffering Physician's Office

- Please send us any relevant medical records.
- Please have patient bring any relevant films or scans.
- Please direct all correspondence to our Fresno Office address.

Appointment Information - SECTION TO BE COMPLETED BY DAAENT

Physician _____

Appointment Date _____ / _____ / _____ Time _____

Scheduler _____ Date_____