



DE MERA

540 E. Herndon Ave.
 Suite 101
 Fresno, CA 93720
 559 431 0340
 559 431 0301 fax
 www.DeMeraAllergy.com

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
- Bret E. Sherman M.D., Ph.D., FACS
- Jennifer Ruch CPNP
- Jessica Halstead FNP-C
- Maelyn McCarty CCC-SLP

Note to Referring 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 DAAIC

Physician _____

Appointment Date ____ / ____ / ____ Time _____

Scheduler _____

Date _____