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## New Patient Referral Form

*This form must be completed and sent with the requested information for patient to be scheduled.*

Fax To: (828) 667-2198 Attention: Tonya

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ For Confirmation

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ email: \_\_\_\_\_

Insurance: ☐ Medicare ☐ Medicaid ☐ BlueCross ☐ Cigna Other: \_\_\_\_\_

\*Note-we participate with most insurance companies **EXCEPT** United HealthCare Commercial Plans.

 **Please Send a Clear Copy of Insurance Card(s)** 

### Diagnosis:

- ☐ **Diabetes** Last A1C Results: \_\_\_\_\_ ☐ **Other:** \_\_\_\_\_  
☐ **Hypothyroidism** ☐ **Hyperthyroid** (Need Medical Records to Determine Urgency)  
☐ **Osteoporosis** (Last Bone Density, Vitamin D)

 **Please Send Last 2 Office Visits and Last 2 Lab Reports** 

***\*\*If you do not send all the required information,  
your patient will not be scheduled.\*\****

Thank you for your referral!

AEC Use: Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician: \_\_\_\_\_