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NEW PATIENT REFERRAL
Fax to (850) 994-1206

Thank you for your referral. Please provide the following information and fax this form to our office.
Please also send: ❑ background medical records and records related to the presenting concerns.

We do ask that the family complete our patient history form prior to an appointment date being assigned. We will contact the family as soon as possible to send out this paperwork along with directions to the office, or they may locate our new patient paperwork on the website (www.drkhagerott.com). *Please let us know* if there is an urgency to the appointment and an appointment is needed sooner than our next available new patient appointment date.

Today's Date: ____________________

Patient's Name:_______________________________________ DOB: _______________ Age:__________

Address: ____ City: ___________ State:______ Zip: ______

Home Phone Number: _________________________________

Contact for appointment: Lives with: ❑ parents ❑ mother ❑ father ❑ other:

Mother's Name _________________________ Cell # ________________ Work # ____________________

Father's Name _________________________ Cell # ________________ Work # ____________________

Reason for Referral: ____

____

Concurrent medical diagnoses: ____

Primary Insurance: ______________________
Policy Number: _________________________
Insured's Name: ________________________
DOB: _______________ SS# _______________
Authorization Number: ___________________

Secondary Insurance:_______________________
Policy Number: ____________________________
Insured's Name: ___________________________
DOB: _______________ SS# __________________
Authorization Number: ______________________

Referring Doctor: ____

Best office person to contact about this referral ___________ Office number: _______________
Office Address: ______________________________________ Office fax: ____________________

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Appointment scheduled for: ____________________ Family notified: ________ Packet sent: ____________