## PROVIDER

- ☐ First Available Option
  - ☐ Pain Management
  - ☐ Chiropractic
- ☐ Requested Provider: ____________________

## REGENERATIVE MEDICINE

- ☐ Dr. Griffee
- ☐ Dr. Montgomery

## PLEASE INCLUDE

- ☐ Last Office Note
- ☐ Radiology Reports
- ☐ Previous Pain Management Records (if applicable)
- ☐ Copy of Authorization
- ☐ Copy of Insurance Card
- ☐ Copy of Driver's License

## HELPFUL INFORMATION

- Referrals are valid for 90 days
- We make at least 3 attempts to contact before suspending efforts
- Providing all requested information at the time of submission greatly reduces the amount of time it takes to schedule
- All referrals are contacted within 3 business days

**newpatientcoordinator@clearwaypain.com** *(Preferred Method of Communication)*

**Phone Number:** *(850) 484-4080* Option 1

**Fax Number:** (833) 810-1165 (Pain Management & Chriopractic)

NEW PATIENT PAPERWORK IS AVAILABLE AT WWW.CLEARWAYPAIN.COM

# NEW PATIENT REFERRAL SUBMISSION FORM

Date: ____________________ Contact Person: ______________________________

Referring Doctor: ______________________________________________________

Phone: (_______) ____________________________ Fax: (_______) _______________

E-Mail: __________________________________________________________

## PATIENT INFORMATION

Name: ____________________________________________________________

DOB: __________________ SSN: ___________________________ Gender [ ] M [ ] F

Phone: (_______) ______________________ Alternate Phone: (_______)______________

E-Mail: __________________________________________________________

Address: _________________________________________________________

__________________________________________________________________

Diagnosis Code and Description: _____________________________________________

__________________________________________________________________

## IF WORKER'S COMP OR MVA

DOI/DOA: ______________________ Adjuster Name: ___________________________

Adjuster Phone: (_______) __________________________________________________

## INSURANCE INFORMATION

Carrier: __________________________________________________ [ ] PPO [ ] HMO

Subscriber Number: _____________________________ Group Number: ____________