Paladin Dermatology

Physician Referral Form

PLEASE FAX OR EMAIL TO THE FOLLOWING LOCATION:

44 A Medical Park Blvd.
Petersburg, VA 23805

Tel: (804) 835-6777
FAX: (804) 835-5103

info@paladinderm.com
(make subject header: "referral")

For faster referral processing, please complete ALL information below and fax or email to our office along with a copy of the front and back of the insurance card(s). We will schedule the appointment and fax this form back to your office. When you notify the patient of the appointment date and time, please remind them to call the customer service number on their insurance card to verify that we are in their network. Also, please remind them of the following:

- **Arrive 15 minutes before appointment time** (patient forms and information at www.PaladinDerm.com)
- **Bring photo ID, ins. Card(s), current medication(s)**
- **Minors must be accompanied by parent or legal guardian**

REFERRING PRACTICE INFORMATION

Date: __________ Practice Name: ____________________________ Referring Provider: _____________________

Referring Provider's email (for follow up communication): ____

Mailing Address: ________________________________ City: ________________ St: _________ Zip: ________

Phone: _______________________ Ext.: _____ Fax: _____________ Form Completed by: __________________

PATIENT INFORMATION

Patient Full Name: ____ E-Mail: ________________________________

DOB: _____ Sex: ____ Marital Status: _____________ Social Security #:______________________________

Address: ____ Apartment #: ______________

City: ______________________________________ State: __________________ Zip Code: __________________

Home Phone: ______________________Cell Phone: _______________________Work Phone:________________

Reason for referral: ____

(If referral is for a biopsy proven skin cancer, please fax a copy of the pathology report with this form)

INSURANCE INFORMATION

If patient is a minor, please provide parent / legal guardian information for insurance purposes:

Primary Insurance: _____________________________ Policy #: ____________________ Group #: ____________

Primary Cardholder's Name: ___________________________________ SSN: ______________________________

Relationship to Patient: ___ Self ____Spouse ____ Dependent

Secondary Insurance: ___________________________ Policy #: ____________________ Group#: _____________

Secondary Cardholder Name: ___________________________________ SSN: _____________________________

Secondary Cardholder Relationship to Patient: ___ Self ____Spouse ____ Dependent

Secondary Cardholder DOB: _____________

Appointment date: _____________________ @ _________ am/pm, with ________________________________

Thank you for your referral!
www.PaladinDerm.com