PORT CITY ORTHOPAEDICS, PLLC
5305 Wrightsville Avenue, Ste G
Wilmington, NC 28403
Phone: 910-791-4492
Fax: 910-791-4355
Email: info@portcityortho.com

REFERRING DOCTOR REQUEST FORM

Date Request Mailed/Faxed:____________________ Date Returned:____________________

REFERRING DOCTOR INFORMATION	
Physician Name:	UPIN: ______________________ NPI: ______________________
Specialty:	Nurse/Contact's Name: ☐ Patient to be called with appt ☐ Referring MD office to be called with appt
Telephone Number:	Fax #:
Supporting Information Request: If there are no pertinent office notes, x-rays, or labs to send with the referral, a statement by the referring MD as to why the patient is being referred is sufficient. We will provide an appointment date and time as soon as possible. Thank you for your assistance and for your referral!	The first available appointment with Dr. Hickey will be given, or specify a day of the week and/or time. Every reasonable effort will be made to honor specific appointment date and/or time requests. ______________________________
FAX TO 910-791-4355	**FAX TO 910-791-4355**

PATIENT INFORMATION	
Diagnosis:	Telephone # ☐ Home: ____________________ ☐ Work: ____________________ ☐ Other: ____________________
Patient Name:	Social Security Number:
Patient Address:	Date of Birth:

INSURANCE INFORMATION	
Primary Insurance:	Secondary Insurance:
Name of Cardholder/Relationship to Pt:	Name of Cardholder/Relationship to Pt:
Subscriber #: Group #:	Subscriber #: Group #:
Self Pay patients are required to pay prior to being seen. The charge for the initial visit is $350, and $150 for each subsequent visit. Patients further agree to pay for charges in excess of these amounts on the day of their visit. Patients will be refunded any negative balance.	

Appointment Date/Time: ________________________________ Scheduler:________________