

New Patient Referral Form

The following information is required to schedule your patient with Headache Care Center. Please return the completed form by **fax to 417-890-8827**. Include a legible copy of the front and back of all insurance cards. Your office will be notified of the time and date of the appointment.

Schedule with: First Available Kent Dexter, MD Curt Schreiber, MD Roger Cady, MD

Please Select: Consultation only with report 1 week Intensive Program
 Evaluate and treat as indicated, send copy of records

Referring Physician:

Physician Name: _____ NPI#: _____ UPIN #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Is the Referring Physician the PCP? Yes No If no, PCP Name and Phone: _____

Patient Information:

Name: (first, middle, last) _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Numbers: Home _____ Cell _____ Work _____
DOB: _____ Social Security #: _____
Best time to call patient: _____ Is it okay to contact patient at work? Yes No

Insurance Information: *Please include legible copy of front and back of all insurance cards.*

Primary Insurance Company: _____ Insurance Phone: _____
Name of Insured (if other than patient): _____
Insured's DOB: _____ Insured's Social Security #: _____
Insurance ID #: _____ Group #: _____

Secondary Insurance Company: _____ Insurance Phone: _____
Name of Insured (if other than patient): _____
Insured's DOB: _____ Insured's Social Security #: _____
Insurance ID #: _____ Group #: _____