Community Bariatric Surgeons
Specializing in Bariatric and General Surgery
7250 Clearvista Suite #100
Phone: 317-621-7771 Fax: 317-621-6040

Referring Physician Form - Please Fax to 317-621-6040

PATIENT:_____

STREET ADDRESS: _____

CITY:_____ STATE: _____ ZIP CODE: _____

HOME PHONE:_____ WORK#_____CELL#_____

DATE OF BIRTH: _____AGE:_____SS#: _____

REFERRING PHYSICIAN: _____

Address: _____

City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Physician NPI #_____

PRIMARY INSURANCE COMPANY (or fax copy of insurance card front and back):

_____
Name of Insured: _____
Employer: _____
Member ID#: _____ Group/Plan #: _____
Insurance Company Telephone Number: _____

SECONDARY INSURANCE:_____

Company/ Network: _____
Name of Insured : _____

EMPLOYER: _____
Or Member ID#: _____Group/Plan #: _____
Insurance Company Telephone Number: _____

Reason for visit

Bariatric Surgery Referral	☐ YES	☐ NO	OTHER: Please Explain
Gallbladder Referral	☐ YES	☐ NO	_____
GERD Referral	☐ YES	☐ NO	_____
Hernia Referral	☐ YES	☐ NO	_____

OFFICE USE ONLY: Appointment date and time: _____

Date instructions mailed: _____Info obtained by :_____