



PHYSICIAN REFERRAL DATABASE QUESTIONNAIRE
PLEASE FILL OUT ONE FOR EACH PRACTITIONER IN YOUR GROUP

(PLEASE FAX TO MEDICAL AFFAIRS 470-7649)

Name: _____

Address: _____

Alternate Address (if applicable):

Name of Practice: _____

Fax: _____

Phone: _____

Accepting New Patients: YES NO

Hours of Operation: _____

Insurance Accepted: _____

Medicaid: YES NO Yes- see list

Gender: _____

Specialty: _____

Board Certifications Held:

Years in Practice: _____

Number of Practitioners in Group: _____

Other Specialties within Group: _____

Handicapped Accessible: Yes _____ No _____

Languages Spoken: _____

Website: _____