Advanced Surgical Care, P.C.

David T. Cozart, M.D., F.A.C.S. ☐

David S. Therrien., M.D., F.A.C.S. ☐

FIRST AVAILABLE ☐

*** PLEASE INDICATE PROVIDER YOU WISH TO SEE***

1120 S. Jackson Hwy Suite 203
Phone: 256-314-6947 Fax: 256-314-6902

Referring Physician:_____ **Date:**_____

Office Contact:_____ **Phone:**_____

Emergent? Yes or No

Patient Name:_____

DOB:_____ **SSN#**_____

Male/Female_____ **Phone:**_____

Address:_____

Reason for Referral:_____

Primary Insurance: Policy Number, Group Number, Policy Holder and DOB:

_____

Secondary Insurance: Policy Number, Group Number, Policy Holder and DOB:

_____

Any Testing Performed? Yes No **Please fax recent office visit and any tests**

If yes, what tests:_____

Date:_____ **Facility:**_____

IN ORDER TO AVOID APPOINTMENT DELAYS PLEASE FAX ALL RECORDS/RESULTS WITH THIS FORM AS WELL AS ANY REFERRALS REQUIRED BY THE PATIENT'S INSURANCE COMPANY TO (256) 314-6902*