

AUGUSTA WEST DERMATOLOGY

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www.augustawestderm.com

Referring Physician: _____ NPI #: _____

Date: _____ Phone: _____ Fax: _____

Patient Data

Patient: _____

Sex: M F

Home address: _____

Phone: _____

DOB: _____

SSN: _____

Employer: _____

Parents' Data if Patient is a Minor

Parent/Guardian: _____

Sex: M F

Home address: _____

Phone: _____

DOB: _____

SSN: _____

Employer: _____

Primary Insured's Information: Employer: _____

Full Name: _____ DOB: _____

SSN#: _____ Policy ID: _____ Group #: _____

Insurance: _____ Phone # for Benefits/Eligibility: _____

Reason for referral with diagnosis code: _____

Please **list** prior and current medications for condition **with percentage if topical**

(eg hydrocortisone 2.5%): _____

**Please fax this form to (706) 922-7999 and send a copy of enlarged insurance card.
Thank you!**