DATE FAXED:_____

MID MICHIGAN VASCULAR SURGERY
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NEW PATIENT INTAKE FORM

EPIC MRN: _____
PATIENT NAME: _____ DOB:_____
SS#:_____ PHONE #:_____ CELL#:_____
PRIMARY INSURANCE: _____ IS PT SUBSCRIBER: YES /NO
IF NO: WHO: _____ THEIR DOB: _____
IF SECONDARY INSURANCE: _____ IS PT SUBCRIBER: YES /NO
IF NO: WHO: _____ THEIR DOB: _____
IF THIS IS COMP CASE OR AUTO CLAIM PLEASE INCLUDE CLAIM NUMBER & DATE OF INJURY HERE:_____

REASON FOR REFERRAL (include ICD-10 and description) _____
REFERRING PHYSICIAN: _____ if NP or PA please include MD that they are under
PHONE#:_____ FAX#:_____
CONTACT PERSON: _____
IF NOT PT PCP PLEASE INCLUDE WHO IS HERE: _____
PHONE#:_____ FAX#:_____

PLEASE **INCLUDE** WITH THIS FORM AS YOUR COVER SHEET ALL OF THE FOLLOWING:

- ☐ DEMO SHEET
- ☐ INSURANCE CARD(S) COPIES (FRONT AND BACK OF CARD IS NEEDED)
- ☐ AUTHORIZATION IF ONE IS NEEDED FOR THIS APPT (if # write here: _____)
- ☐ ANY PERTINENT TESTING THAT OCCURRED OUTSIDE OF EPIC EMR

_____OFFICE USE ONLY_____

APPT INFORMATION
BAYS: _____
KIM: _____
TESTING NEEDED: _____

1ST CONTACT: _____

2ND CONTACT: _____

3RD CONTACT (NOTIFY REF DR.): _____

☐ NEW PACKET SENT