REFERRAL TO DECATUR ENT
Phone: 256-355-6200
Fax: 256-355-6241

Patient Name: _____

DOB:_____

Mailing Address:_____

Phone: _____

Email: _____

Insurance Type: _____

Contract Number: _____

Group Number: _____

Referral Reason: _____

Scans: _____

Preferred Day / Time: _____

Social Security Number: _____

Referring Doctor: _____

Referring Doctor's Phone Number: _____

Referring Doctor's Fax Number: _____

Contact at Office: _____

Due to TCPA Regulations please send a copy of signed authorization of how we may communicate with patient.

Doctor Preferred: Copeland (1265413124) Godwin (1558342931)

Light (1760463632)

First Available No Preference