ADVANCED THORACIC

James R. Fenton, MD
Christina S. Glenn, MD

1675 Watertower Place, Ste 100
East Lansing, MI 48823
Phone: 517-999-4370
Fax: 517-999-4371
www.advancedthoracic.com

New Patient Referral Form

Reason for Referral (Diagnosis): ____

Surgeon Requested: ◯ Dr. Fenton ◯ Dr. Glenn ◯ First Available

Referring Provider Information

Referring Provider: ______________________________ Referring Phone: ___________________________

Referring Practice: ______________________________ Referring Fax: _____________________________

Referring Practice Address: ______________________

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Patient Demographic Information

Patient Name: ______________________________ Date of Birth: ____________________________

Address: ___________________________________ Phone: _________________________________

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Patient Insurance Information

Primary Carrier: ______________________________ Secondary Carrier: ________________________________

Plan: ____ Plan: ____

Member ID: _________________________________ Member ID: ______________________________________

Please attach copy of patient insurance card and photo ID if available

Please send referral checklist and documentation to our office to complete referral. If you have any questions or need assistance, please call our office at 517.999.4370