AFFILIATED DERMATOLOGISTS

DERMATOLOGY REFERRAL FORM

affiliatedderm.com

Referral Date: _____

1 OFFICE LOCATION

- ☐ Brookfield, WI
- ☐ New Berlin, WI
- ☐ Oak Creek, WI
- ☐ Waukesha, WI
- ☐ Germantown, WI
- ☐

2 PATIENT DETAILS

CONTACT INFORMATION

Name: _____

DOB: _____

Address: _____

_____

Phone: _____

☐ MALE ☐ FEMALE

INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____

Secondary Insurance: _____

ID Number: _____

WE DO NOT ACCEPT MEDICAID HMO PLANS
PATIENT CAN BE SELF PAY

3 REFERRING PHYSICIAN

CONTACT INFORMATION

Name: _____

Phone: _____

Fax: _____

4 SCHEDULING

WHEN DO THEY NEED SCHEDULED?

☐ URGENT ☐ ROUTINE

5 REASON FOR REFERRAL

DIAGNOSIS

- ☐ Mohs
- ☐ Lesion
- ☐ Rash
- ☐ Acne
- ☐ Other: _____

Body Location: _____

Please fax this form and supporting documents including insurance cards to (262) 754-4940

P: (262) 754-4488 | F: (262) 754-4940 | email: receptionist@affiliatedderm.com