Ardavan M. Aslie, M.D.

Orthopedic Spine Surgeon

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ROSEVILLE, CA 95661
OFFICE (916) 771-8819
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CONSULTATION REQUEST FORM FOR - ______________________

lumbar, cervical, thoracic, carpal tunnel

Please fax **this form** with **MRI reports (closed MRI)**, any **Epidural Steroid Injection reports**, **Physical Therapy Reports**, **Office Notes**, **Current Medication List** and copy of **Insurance Cards** to (530) 743-8814 or (916) 645-8362. New patient paperwork can be printed from website www.spinetreatmentcenter.com. Please inform the patient that they will need to get all MRI **films** and bring them to their appointment or the appointment will be rescheduled.

PATIENT: ______________________ DOB: ______________

➔ ADDRESS: ______________________________________

CITY: ______________________ ZIP: ______________

HOME PHONE: ____________ WORK: ____________ CELL: ____________

SOCIAL SECURITY NO: ______________________________

INSURANCE INFORMATION Please provide copies of current insurance cards. Co-Pay:_____

➔ NAME: ______________________________________

ADDRESS: ______________________________________

SUBSCRIBER ID#: ______________ GROUP #: ______________

INSURED NAME: ______________ DOB: ______________

INSURED ADDRESS: ______________________________

INSURED SSN: ______________ Relationship to patient: ______________

WORKERS' COMPENSATION **Primary Treating Physician:** ______________

COMPANY: ______________________________________

ADDRESS: ______________________________________

ADJUSTOR: ______________________________________

ADJUSTOR PHONE : ______________ ADJUSTOR FAX: ______________

DOI: ______________ CLAIM NO: ______________

AUTHORIZED BY: ______________________________

REQUESTING PROVIDER: ______________________________

➔ NAME: ______________ NPI# ______________

LICENSE #: ______________ UPIN #: ______________

ADDRESS: ______________________________________

PHONE: ______________ FAX: ______________

CONTACT PERSON: ______________________________

____

Requesting Provider's Signature

****THIS FORM MUST BE SIGNED BY THE REQUESTING PROVIDER.**

FOR OFFICE USE ONLY		
1.	MRI (date/location)	
2.	Demographics	
3.	Insurance Card	
4.	Office Notes	
5.	Requested by:	
6.	Medication list	