MORS Maxillofacial Oncology & Reconstructive Surgery

# REQUEST FOR ORAL & MAXILLOFACIAL SURGERY CONSULT

Date: ____________________

Diagnosis Code/Reason for Referral:

Patient Name: _________________________ _________________________ _____ ___________

Last First MI Suffix

Language: _______________________ Sex: _______ DOB: ________________ SS#: ___________________________

Patient's Address: _________________________________________________________________________________

City: ___________________________ State: ______ Zip: ___________ Patient's Phone #: _____________________

Patient's Insurance: ___________________________________________ Insurance ID #: _______________________

Subscriber (if not self): ________________________________________ Relationship: ________________________

SS#: ___________________________ DOB: ______________________

HMO Authorization #: _______________________ Out of Network Authorization #: ______________________

**Referring Doctor Info:**

Name: _____________________________________________________ Phone: _______________________________

Office Contact Person: ________________________________________ Fax: __________________________________

## RADIOGRAPHS OR CLINICAL PHOTOS

☐ Being Mailed ☐ Given to Patient ☐ Please Take ☐ No X-Ray

☐ Attach X-Rays with this form via email.

**Fax this form and ALL attachments to (817) 702-1117 or e-mail to accresourcectr@jpshealth.org.**

Patient Access Center phone number (817) 702-1100