



DEMERA

540 E. Herndon Ave.
 Suite 101
 Fresno, CA 93720
 559 431 0340
 559 431 0301 fax
 www.DeMeraAllergy.com

PATIENT REFERRAL

Instructions:

1. Please print the most current information for the patient as requested below or attach most current face sheet. Be sure to complete all sections.
2. Fax in this form to our office: (559) 431-0301
3. Within 24 hours, we will complete the appointment section at the bottom of this form and fax it back to you.
4. Upon your receipt of our form, please notify the patient of the appointment date and time.

Patient Information

Patient's Full Name: (First) _____ (Last) _____

Patient's Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Marital Status: Single Married Other Sex: Male Female

Emergency Contact: Full Name _____ Phone: (____) _____

Insurance Information

Primary Insurance Coverage

Secondary Insurance Coverage

Insurance Company: _____

Physician Information

Referring M.D. _____ NPI# _____ Fax # _____

Diagnosis Description (not code) _____

Dr. DeMera - Office: Fresno Visalia

Dr. Bret Sherman

Jennifer Ruch CPNP

Jessica Halstead FNP-C

Karen Segovia CPNP

Note to Referring Physician's Office

- Please notify patient of appointment date & time as soon as possible.
- Please have patient stop any antihistamines 4 days prior to appointment.
- Please send us any relevant medical records.
- Please have patient bring any relevant films or scans.
- Please direct all correspondence to our Fresno Office address.

Appointment Information - SECTION TO BE COMPLETED BY DAAIC

Physician _____

Appointment Date ____ / ____ / ____ Time _____

Scheduler _____

Date _____