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)_____

_____

- ○ Richard S. DeMera M.D. - Office: ☐ Fresno ☐ Visalia
- ○ Bret E. Sherman M.D., Ph.D., FACS
- ○ Jennifer Ruch CPNP
- ○ Jessica Halstead FNP-C

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_____