BURKHART & CHAPP CHIROPRACTIC PLC
Innovative Health Care Solutions

Fast Track Scheduling Referral to:

___ Dr Timothy J. Burkhart
___ Dr James A. Chapp
___ Dr Patrick A. Moultrie
___ Dr Ryan M. Burkhart

After Calling our office to make an appointment, please fax this completed form to our scheduling department at 616.698.0046. Thank you for the referral.

Patient Name:_____ Date:_____
Social Security No:____/____/____ Date of Birth:_____/_____/_____ Phone #:_____

Referring Physician:_____ Phone #: _____
Referring Office Contact:_____ Fax #: _____

Patients Current Diagnosis:_____

Reason for Referral:

___ Evaluate Only ___ Candidate for Cervical Spinal Decompression
___ Evaluate and Treat ___ Candidate for Lumbar Spinal Decompression
___ Other:_____

Previous Studies/Treatments and Location where performed:

___ Xrays When?_____ Where?_____
___ CT Scan When?_____ Where?_____
___ Discogram When?_____ Where?_____
___ Pain Management When?_____ Where?_____
___ MRI When?_____ Where?_____
___ Other_____
___ Previous Back Surgery? ___ Yes ___ No If yes, where and who?_____

___ Face Sheet included with this fax referral sheet
___ Insurance Information is included with this fax referral sheet **OR** ___ See Insurance Information Below

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced
Spouse's Name: _____
Patient Address:_____

Employer: _____

Is this work or Auto related? ___ No ___ Yes If yes, please provide Claim No: _____
Date of Injury:_____ Insurance Carrier: _____
Adjuster Name: _____ Phone #: _____

Primary Insurance: _____
Contract Number: _____ Insured Name: _____
Group Number: _____ Insureds Date of Birth: ____ / ____ / ____
Employer: _____

Secondary Insurance: _____
Contract Number: _____ Insured Name: _____
Group Number: _____ Insureds Date of Birth: ____ / ____ / ____
Employer: _____

BCC OFFICE USE:
Appointment Date: _____ Time: _____ Dr:_____

7101 Broadmoor Ave. SE ~ Caledonia, MI 49316 ~ 616.698.0046 ~ Fax 616.698.2188