Headache Wellness Center

1414 Yanceyville St Greensboro, NC 27405 (PH)336-574-8000 (FAX)336-574-8008

HEADACHE/MIGRAINE REFERRAL SHEET

Patient Information		
Patient Name:		DOB:
Address:		
City:	State:	Zip
Home #	Work #	Cell #
Insurance Information – **Please fax a legible copy of card. If not available, fill in information.**		
Primary Insurance:		
Policy #:		Group #:
Secondary Insurance:		
Policy #:		Group #:
Referring Provider Information:		
Referring Provider:		
Phone #:	Fax #:	NPI#
Contact Person:		

Please fax records regarding your treatment of this patient's headaches including any MRIs and CT reports, EKG and Lab Results (if within last 6 months)

Thank you for this referral!

We will contact the patient directly to schedule. We will return this page back to you by fax to inform you of when your patient is scheduled.

The above patient has been scheduled with Dr. Marshall C Freeman

On ___________________________ at _______________ am/pm

5/24/2022