

# The Joint and Spine Pain Center

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## PATIENT INFORMATION

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

## REFERRAL INFORMATION

DATE OF REQUEST: \_\_\_\_\_

REFERRING PROVIDER: \_\_\_\_\_

NPI # for REFERRING PROVIDER: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

REFERRAL REASON: \_\_\_\_\_

ICD 10 CODE: \_\_\_\_\_

PLEASE SEND WITH THIS RERERRAL:  PATIENT DEMOGRAPHICS

COPY OF INSURANCE CARD (S)

MEDICATION LIST

LAST 6 MONTHS OF RECORDS (INCLUDING OPERATIVE REPORTS, X-RAYS, MRI'S)

**IF RECORDS ARE MORE THAN 20 PAGES, PLEASE MAIL THEM. DO NOT FAX.**

**WE WILL CONTACT YOUR PATIENT WITH AN APPOINTMENT WITHIN 48 HOURS OF THIS REQUEST**

We are NOT in network with the following insurances:

UHC-Americhoice	Aetna
BCBS Network E	BLUECARE
Cigna Healthsprings	Cigna Connect
Wellcare	Windsor
KY Medicaid(s)	Mailhandlers