

# St. Anthony's Medical Center Health Access Questionnaire Physician Referral

Are you interested in participating in the referral service?  Yes  No

Are you currently accepting new patients?  Yes  No

### Physician Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phonetic Spelling, if... \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender:  Male  Female

Degree:  M.D.  D.O.  D.D.S.  D.M.D.  D.P.M.

Do you accept...  Yes Age range \_\_\_\_\_

Type of...  Group  Individual

Name of Practice: \_\_\_\_\_

Situations where you would not like to receive a... \_\_\_\_\_

\_\_\_\_\_

### Education & Certification

Year began practicing... \_\_\_\_\_ Year began practicing in... \_\_\_\_\_

### Education & Certification

	Hospital/Facility	Specialty	Dates
Medical Degree			
Internship			
Residency(ies)			
Fellowship(s)			

### Board Certifications

Specialty(ies)	Board Certified? Y/N	Accept referrals for this specialty? Y/N
Primary		
Secondary		
Other		

**Primary Office Location**

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone... \_\_\_\_\_ Fax #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Is public transit...  Yes  No Is your office handicap...  Yes  No  
Office Hours: \_\_\_\_\_  
  
Office manager/contact... \_\_\_\_\_

**Secondary Office Locations**

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone... \_\_\_\_\_ Fax #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Is public transit...  Yes  No Is your office handicap...  Yes  No  
Office Hours: \_\_\_\_\_  
  
Office manager/contact... \_\_\_\_\_

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone... \_\_\_\_\_ Fax #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Is public transit...  Yes  No Is your office handicap...  Yes  No  
Office Hours: \_\_\_\_\_  
  
Office manager/contact... \_\_\_\_\_

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone... \_\_\_\_\_ Fax #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Is public transit...  Yes  No Is your office handicap...  Yes  No  
Office Hours: \_\_\_\_\_  
  
Office manager/contact... \_\_\_\_\_

**Practice Information**

Same Day Appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Meet & Greet Visits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Length of Visit _____	Fee _____
Special Services:	_____			
Non-English languages...	_____			
Other...	_____			
Please provide any key words that would help us to customize referrals to your practice.				
_____				
_____				

**Payment Policy**

		Yes	No			Yes	No
Method of Payment	Cash	<input type="checkbox"/>	<input type="checkbox"/>	American Express	<input type="checkbox"/>	<input type="checkbox"/>	
	Check	<input type="checkbox"/>	<input type="checkbox"/>	Discover Card	<input type="checkbox"/>	<input type="checkbox"/>	
	Visa	<input type="checkbox"/>	<input type="checkbox"/>	Insurance Billed	<input type="checkbox"/>	<input type="checkbox"/>	
	Mastercard	<input type="checkbox"/>	<input type="checkbox"/>				
Other notes regarding...		_____					