HEALTHPOINTE

Consultation / Treatment Request

Patient Name: ______________________ Today's Date: ______________
Patient's Phone: (Work): ____________ (Home): ____________ (Cell): ____________
Patient's SS#: ______________________ Patient's DOB: ______________
Patient's Address: ____
City:______________ State: ________ ZIP:__________ Date of Injury: ______________
Requested Appt Date: ______________________ Requested Appt Time: ______________

Office where patient is to be seen:

- ☐ 1717 E. Lincoln Ave., **Anaheim**, CA 92805
- ☐ 1171 Railroad St., Suite 101, **Corona**, CA 92882
- ☐ 10900 Warner. Suite 121, **Fountain Valley**, CA 92708
- ☐ 7052 Orangewood Ave, Suite 6, **Garden Grove**, CA 92841
- ☐ 311 N. Verdugo Rd., **Glendale**, CA 91206
- ☐ 5345 Irwindale Ave., **Irwindale**, CA 91706
- ☐ 5722 Bellflower Blvd., **Lakewood**, CA 90713
- ☐ 16702 Valley View Ave., **La Mirada**, CA 90638
- ☐ 754 N. Mountain Ave., **Ontario**, CA 91762
- ☐ 2226 Medical Center Dr., Suite 102, **Perris**, CA 92571
- ☐ 28991 Old Town Front St., Suite 104, **Temecula**, CA 92590

Referring Dr: ______________________
Dr. Address: ______________________
Dr. City/St/Zip: ______________________
Dr. Phone: ______________________
Dr. Fax: ______________________
Dr. Email: ______________________

Attorney: ______________________
Atty Address: ______________________
Atty City/St/Zip: ______________________
Atty Phone: ______________________
Atty Fax: ______________________
Atty Email: ______________________

Services Requested

- ☐ Evaluate & Treat
- ☐ Evaluate & Co-Treat
- ☐ Consultation Only w/ Report
- ☐ Specialty: ______________________

- ☐ PT and/or Chiro to be done at Healthpointe
- ☐ PT and/or Chiro to be done at (Fill in name): ______________________

Dr(s) Requested: ______________________
X-ray Views Taken: ______________________
MRI's: ______________________

- ☐ PI-Lien
- ☐ PI-Med Pay
- ☐ PI-Health Insurance
- ☐ Worker's Comp.
- ☐ Health Insurance
- ☐ Medicare

Dispense Necessary Medication ☐ YES ☐ NO

FAX OR ATTACH ALL PATIENT RECORDS

Insurance Information

Insurance Co.: ______________________ Phone: ______________________
Ins. Address: ______________________ Policy #: ______________________
Ins. City/St/Zip: ______________________ Claim #: ______________________

Area(s) of Primary Concern & Relevant Clinical History

To schedule an appointment you may choose to call, e-mail or fax this form to:

Call: (951) 893-9130 **Fax**: (714) 367-5378

E-mail: *PI referrals*: PI@healthpointemd.net • *W/C referrals*: WC@healthpointemd.net

For Further Personalized Assistance please contact Dr. Stephen Herman @ 888-795-0555

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