

Henry Ford Specialty Center - Grayling Phone: (877) 434-7470 • Fax: (313) 916-5717

New patient Updated patient information (if updated information please fill of name, date and date of birth only unless changes have occurred Patient name	Date:	Form completed by:		
Address State	☐ New patient ☐ Updated patien	t information (if updated information please fill ot	name, date and date of birth only unless changes have occurred	
Address State	Patient name		DOB (Date of birth)	
City State Zip Phone Alt. Phone Diagnosis Reason for referral Provider Requested (if known): Timeframe?				
City State Zip Phone Alt. Phone Diagnosis Reason for referral Provider Requested (if known): Timeframe?	Address			
Diagnosis Diag			Zip	
Reason for referral	Phone	Alt. Phone		
Provider Requested (if known): Timeframe? Urgent / Next Available Routine Referring Physician Primary Care Physician Address City, State, Zip City, State, Zip Phone Phone Fax Fax Email Email INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following): Primary Insurance Policy Holder Insurance company name ID/Policy # Group Phone Secondary Insurance Policy Holder Insurance company name Employer name Secondary Insurance Policy Holder Insurance company name Group Phone Phone	Diagnosis			
Timeframe? Urgent / Next Available Routine Referring Physician Primary Care Physician Address Address City, State, Zip Phone Phone Fax Fax Email INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following): Primary Insurance Insurance company name ID/Policy # Group Policy Holder Insurance company name Employer name Secondary Insurance Policy Holder Insurance company name Fax Group Phone Phone Phone Phone Phone Phone Phone Phone	Reason for referral			
Timeframe? Urgent / Next Available Routine Referring Physician Primary Care Physician Address Address City, State, Zip City, State, Zip Phone Phone Fax Fax Email INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following): Primary Insurance Insurance company name ID/Policy # Group Policy Holder Insurance Company name Employer name Secondary Insurance Policy Holder Insurance company name Fax Group Phone				
Address				
City, State, Zip City, State, Zip	Referring Physician	Primary Care Physic	Primary Care Physician	
Phone Phone Phone	Address	Address	Address	
Fax	City, State, Zip	City, State, Zip	City, State, Zip	
INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following): Primary Insurance Policy Holder Insurance company name ID/Policy # Group Phone Employer name Secondary Insurance Policy Holder Insurance company name ID/Policy # Group Phone	Phone	Phone	Phone	
INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following): Primary Insurance Policy Holder Insurance company name ID/Policy # Group Phone Secondary Insurance Policy Holder Insurance company name ID/Policy # Group Phone	Fax	Fax	Fax	
Primary Insurance Policy Holder Insurance company name Group Phone ID/Policy # Folicy Holder Secondary Insurance Policy Holder Insurance company name Group Phone	Email	Email	Email	
Insurance company name	INSURANCE (attach copy o	f all insurance card(s) Front and B	ack and complete the following):	
ID/Policy # Group Phone Employer name Policy Holder Secondary Insurance Policy Holder Insurance company name Group Phone	Primary Insurance	Policy Holder	Policy Holder	
Employer name Secondary Insurance Policy Holder Insurance company name ID/Policy # Group Phone	Insurance company name			
Secondary Insurance Policy Holder Insurance company name ID/Policy # Group Phone			Phone	
Insurance company name Group Phone	Employer name			
ID/Policy #	Secondary Insurance	Policy Holder		
	Insurance company name			
	ID/Policy#	Group	Phone	

REFERRAL FORM