Spine Surgery Consult Form
Justin W. Miller, M.D.

Indiana Spine Group

Referring Doctor: _____
Contact Number: _____
Fax Number: _____

Patient Demographics & Contact Information

Name _____
Address _____
Home Phone _____
Cell Phone _____
Work Phone _____
E-mail Address _____

Patient Insurance Information

Company _____
Name of Subscriber _____
Subscriber Date of Birth _____
Please fax a copy of the front and back of the insurance card.

Reason for referral: _____

Diagnosis: _____

Worker's Comp? ❍ YES ❍ NO
Motor Vehicle Accident? ❍ YES ❍ NO
Previous Back Surgery? ❍ YES ❍ NO

If prior back surgery, please fax a copy of the office notes and surgery summary.

Other Services

MRI ❍ YES ❍ NO
X-RAYS ❍ YES ❍ NO
PHYSICAL THERAPY ❍ YES ❍ NO

Other Comments / Patient Notes: _____

Patient Scheduled
Date: _____
Time: _____
Scheduler: _____
Patient Notified? ❍ YES ❍ NO

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