



**ADVANCED PAIN
MANAGEMENT
CENTER OF
OKLAHOMA, LLC**

3840 S 103rd East Ave, Suite 100,
Tulsa, OK 74146

Phone: 918-921-9700 Fax: 918-282-8263

Please fax/mail this form along with recent office notes, medication list, all diagnostic reports, front and back of insurance card(s), and insurance referral.

Please call us with any questions at 918-921-9700.

MUST SEND ALL IMAGING

Patient Information:

Name: _____ DOB: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

SS #: _____ Cellular: _____

Insurance Carrier: _____

Diagnosis or presenting problem: _____

Service Requested:

Consult & Management

Consult Only

Procedure Only (specify)

Would you like confirmation of the patient's appointment date/time? yes no

Referring physician: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Please provide the following information ONLY if this is your first time referring to our office.

License #: _____ Tax ID #: _____

UPIN #: _____ Medicaid Provider #: _____

Thank you for your referral!