

**FAX-A-CONSULT**  
**Advanced Pain Treatment Center**  
**Anterpreet S. Dua, M.D.**  
**Fax (864) 466-0289 phone(864) 466-0288**

Patient's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Pain Management Consult     Other: \_\_\_\_\_

Accident  No     Yes    Information: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Patient's Symptom(s): \_\_\_\_\_

Requesting Physician's Name: \_\_\_\_\_

Requesting Physician's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Request Submitted By: \_\_\_\_\_

**Please fax with a copy of the patient's demographic information,  
insurance cards, and problem pertinent medical records.**

Thank you for allowing our practice to participate in your patient's care!

We will call the patient and schedule the appointment.

You can expect prompt appointment confirmation via return fax.

Consulting Office Use:

**Patient's appointment: Date** \_\_\_\_\_ **Time** \_\_\_\_\_