Northeast Surgical Group, P.C.

CORRESPONDENCE INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THOSE PHYSICIANS WHO ARE CURRENTLY MANAGING YOUR CARE…if none apply, please indicate same…***PLEASE INDICATE ONLY THOSE PHYSICIANS WHOM YOU WISH CORRESPONDENCE BE FORWARDED TO – IF THEY ARE LISTED, A LETTER MAY BE SENT. THANK YOU***

★ **PRIMARY PHYSICIAN:** _____ (D.O. / M.D.)

Specialty: *Family Medicine or Internal Medicine* (please circle the appropriate one)

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

★ **CARDIOLOGIST:** _____ (D.O. / M.D.)

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

★ **ONCOLOGIST / HEMATOLOGIST:** _____ (D.O. / M.D.)

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

??? OTHER PHYSICIANS ???

★ _____ (D.O. / M.D.) Specialty: _____

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

★ _____ (D.O. / M.D.) Specialty: _____

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

★ _____ (D.O. / M.D.) Specialty: _____

Address_____City_____ State_____ Zip_____

Phone (_____)_____-_____

My signature below verifies that the information provided on this document is accurate as of today's date:

Patient's PRINTED name: _____ ACCOUNT# _____

FOR OFFICE USE ONLY

_____ _____

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date

*****FOR OFFICE UPDATES ONLY*****

17375 Hall Road, Macomb, MI 48044 *** Telephone 586-228-0550 ***Fax 586-228-8830