# F A X

**TO:**

**Practice:** Alabama Digestive Disorders Center
**Physician:** Smita S. Shah, MD, AGAF
**TEL:** (256) 882 - 7888 **FAX:** (256) 882 - 7886
**WEB:** http://www.AlabamaDigestiveDisordersCenter.com

**FROM:**

**Practice:** _____
**Physician:** _____
**Contact:** _____
**TEL:** ( ____ ) ____ - _____ **FAX:** ( ____ ) ____ - _____

**Patient Information (please send all medical records):**

**Name:** _____
**Date of Birth:** ____ / ____ / _____ **Gender:** _____
**Cell:** ( ____ ) ____ - _____ **Home:** ( ____ ) ____ - _____ **SSN:** ____ - ___ - _____
**Address:** _____
**Diagnosis:** _____
**Date of last Colonoscopy:** ____ / ____ / _____ **if done, polyps?** _____

We accept most major insurances. Some exceptions are: Beechstreet, Champ VA, Essential Staff Care, Fisterv Health, Health Springs, Horizon, Humana, Medicaid, Starbridge, Tricare Prime, VA, VIVA. ALL Medicare patients must have a secondary plan.

| Primary | Secondary | Tertiary |
|---|---|---|
| | | Insurance Name |
| | | Contract \| Group \| From Date |
| | | Name of Insured |
| | | Relationship to Insured \| DOB |

Thank you for referring your patient to Dr. Shah. For same day appointments please call the office at (256) 882-7888. We will contact your patient to notify date, time and place of appointment.

**Appointment Information (to be completed by the ADDC office staff):**

**Physician:** Smita S. Shah, MD, AGAF
**Appointment Day, Date, Time:** _____ , ____ / ____ / _____ at ____ : ____ __m