ABRAHAM BETRE D.O.,M.D.
925 E. Merritt Ave | Tulare, Ca. 93274 Ph. (559) 688-6400 Fax (559) 688-6500
www.Drbetre.com

Referral Form

Today's Date: ____/____/_____

Referring Physician Name: _____

Phone: _____ Fax: _____

Address: _____Office Contact: _____

Patient Name: _____ DOB____/_____/_____

Address: _____ City: _____ Zip: _____

Phone #:_____ Work#:_____

S.S. #: _____/_____/_____

Diagnosis: _____

_____

Insurance Information

Carrier: _____

Name of Insured: _____

Subscriber: _____ Subscriber#:_____

Appointment date: _____/_____/_____ Time: _____

****Please notify your patient of their appointment with us. Thank you. ****

☐ Your Patient did not show for above appointment.