******PHYSICIAN REFERRAL ONLY*****

North Florida Regional Thyroid Center

Celeste B. Hart, MD
Luz Prieto-Sanchez, MD
Robin Byrd, ARNP

DATE:_____

Referring Physician: _____

Phone: _____ Fax:_____Contact:_____

Primary physician: _____

Reason for Visit: *_____

Patient Information

Last:_____ First: _____MI_____

Date of Birth:_____

Address: _____
_____Zip_____

Home phone: _____Work phone: _____Cell_____

Primary Insurance:_____

Policy Number: _____

***Please fax most recent labs and office notes to support visit reason.**

Our office contact: _____

Office use only
Appointment date: _____
Appointment time: _____

Appt is with Doctor/ARNP

Please contact patient with appt

1705 S. Adams Street
Tallahassee, Florida 32301
850-224-7154-Office
850-561-0572-Fax