Orthopaedic Associates of Zanesville

An OrthoAlliance Partner Practice

740-454-3273

APPOINTMENT FAX FORM

www.orthozane.com

Upon completion, please fax form to: (740) 588-1081

Fax referrals will be processed, and patients will be called on the same day as the request.

If your patient requires immediate care, please call our office at (740) 545-3273 to expedite this referral.

Referring Office Information

Your Name/Office: _____ Phone: (____) _____

Referring Physician: _____ Fax Number: (____) _____

Address: _____

Reason for Referral: _____

OAZ Physician: ☐ Benjamin R Pulley, MD ☐ Brad E. Brautigan, MD ☐ Jordan R. Bonier, MD ☐ Joshua Burka, DO ☐ No Preference

Body Part: ☐ Hip ☐ Knee ☐ Shoulder ☐ Hand/Elbow/Wrist ☐ Spine ☐ Foot & Ankle

Patient Information

Patient Name: _____ Gender: ____Male ____Female

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Date of Birth: ____/_____/_____ Social Security Number: ____/_____/_____

Interpreter Needed: _____ Yes _____ No Language: _____

How Did This Injury Occur: ☐ N/A ☐ BWC ☐ Other: _____

Patient Has Completed: ☐ Digital X-rays ☐ MRI ☐ CT ☐ EMG ☐ X-rays ☐ Cast/Splint

Patient Insurance Carrier: _____

Please attach patient demographics and insurance card. We appreciate your completion of this form in its entirety to allow us to better serve your patient.

Office Location

2854 Bell Street
Zanesville, OH 43701

If you have difficulty during the appointment scheduling process, please call **Michelle Hicks, Practice Liaison at (919) 830-5338.**

THANK YOU FOR YOUR REFERRAL!

09/10/25 9:52 AM hb