



Patient Referral Source

Patient Name: _____ DOB: _____ Date: _____

Physician / Provider: _____

Dear New Patient:

We are interested in tracking our referral and marketing sources. Please complete this form and return to the reception / check-in area along with your other paperwork.

Thank you!

How did you hear about our practice? (Please check all that apply)

- Another Physician / Provider: _____
- Friend / Family – word of mouth
- Insurance Company
- Location – Walk-In
- THR referral line
- Phone book
- Direct mail
- Event _____
- TV
- Radio
- Magazine _____
- Newspaper _____
- Other advertisement, where _____
- Practice printed material _____
- Web Search
- Practice Website
- THR / THPG website
- OTHER _____

| |
|--|
| <p>For Office Use Only –</p> <p>Account Number: _____</p> <p>Notes:</p> |
|--|