

PEDIATRIC GASTROENTEROLOGY ASSOCIATES
2577 Samaritan Dr., Suite 815, San Jose, CA 95124
(408) 358-3573 Fax (408) 356-2888
www.pediatricgisanjose.com

REQUEST AN APPOINTMENT FOR A NEW PATIENT

Please complete this form and fax it to **408-356-2888**. Our staff will contact you by phone to schedule a consultation appointment. We will make every effort to meet your scheduling needs.

Patient: _____, _____
Last name First name

Date of Birth: _____

Your Name: _____ Relationship: _____

Reason for Referral to Pediatric GI: _____ *

Has this patient been seen by our doctors at any time in the past? _____ No _____ Yes

If YES, please provide last visit date: _____

Which Physician are you requesting to see in our office? (check one or more)

_____ Marjorie McCracken, M.D. _____ Adel Abi-Hanna, M.D. _____ 1st Available

_____ Anders Dahlstrom, M.D. _____ Laura Ohara, R.N., P.N.P.

Name of patient's Insurance: _____ HMO? Y N

If HMO, the primary care physician must provide your child's *authorization number* from HMO group.

Please provide 2 phone numbers for the staff to reach you: () _____

() _____

IMPORTANT

*Please arrange for the referring doctor to **fax** copies of your child's **medical records** to our office, including all laboratory and x-ray reports, growth charts, and any other pertinent information.

A **fee will be incurred for each missed appointment when **1 business day notification** is not given.

No Doctor-Patient relationship exists until your child is seen in consultation by a provider in our office.