

PEDIATRIC GASTROENTEROLOGY ASSOCIATES  
2577 Samaritan Dr., Suite 815, San Jose, CA 95124  
(408) 358-3573 Fax (408) 356-2888  
[www.pediatricgisanjose.com](http://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: \_\_\_\_\_

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.