

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 to Patient: \_\_\_\_\_

Reason for referral to Pediatric GI: \_\_\_\_\_

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

If so, please provide the date of last visit: \_\_\_\_\_

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

Marjorie McCracken, M.D.

Adel Abi-Hanna, M.D.

P. Christine Nguyen, M.D.

Insurance Company \_\_\_\_\_  HMO  PPO

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

Please provide 2 phone numbers for our staff to contact you: 1. \_\_\_\_\_

2. \_\_\_\_\_

**IMPORTANT**

Please arrange for the referring doctor to **FAX** copies of your child's **MEDICAL RECORDS** to our office.

Please include all

**laboratory reports, radiology reports, growth chart, and any other pertinent information.**

\*If for any reason you need to cancel or change the appointment scheduled, you must do so 1 business day BEFORE the appointment. Otherwise you will be charged a NO SHOW or LATE CANCELLATION FEE.

NO DOCTOR-PATIENT RELATIONSHIP EXISTS UNTIL YOUR CHILD IS SEEN IN CONSULTATION BY A PROVIDER IN OUR OFFICE.