ETCH Pediatric and Adolescent Gynecology

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Please complete the following and return along with the records.

Patient Name: ___________________________DOB:____________

Address: ____

____

Home Phone: ___________________ Cell Phone: __________________

Parent/Guardian Name:______________________DOB:____________

Primary Insurance:_____________________ID#_______________

Policy Holder: ____

Secondary Insurance: _______________________________________

Referring Provider:_______________Phone:________Fax:________

Reason for Referral: _______________________________________

Appointment needed ASAP? YES___ NO___ Office note attached ______

Does this patient need an interpreter? ____________

*****If you have imaging on a disk please send with patients family*****

Appointment Date:________Time:__________ Provider___________

***We will complete the appointment information and return it to you as soon as possible. Please include the office notes for the referral and copy of insurance card. ***