

Doctor _____

Date _____

NEW PATIENT

Name _____ Date of Birth _____

Address _____

City/State _____ Telephone _____

Referring Physician _____
(or Primary Physician)

City _____

Medicare # _____

Medicaid # _____ Other _____

Symptoms _____

Have you seen any other Cardiologist? Who? _____

Have you seen any other Physician for this condition? Who? _____

If the physicians are not able to help you, would you like a referral to another physician for this condition?

Thank you for the information. Because our practice has outgrown our ability to help all patients, we are forced to be selective about the new patients we see. We will do our best to schedule an appointment, however, we are unable to promise that we can see you as a patient.

Yes, I will see this patient.

No, do not schedule an appointment.

Comments: