

APPOINTMENT FAX REQUEST
FAMILY HEALTHCARE ASSOCIATES

Patient's Name: _____

Date of Birth: _____

Account No. (If Known) _____

Date Preferred _____ or First Available _____ A.M. or P.M.

Doctor: _____ 2nd Choice _____ 3rd Choice _____

Insurance _____ Is this new? (Y/N) New Plan Name _____

Reason for
Visit _____

Telephone Number (Days) _____ (Evenings) _____

Signature _____ Date _____

Disclaimer:

We will call you to confirm the date and time of your appointment. If we are unable to accommodate your request we will call you and work with you to find an acceptable appointment time. If you have not received a call back within 2 hours please feel free to re-submit or call us directly at (817) 277-9135.

Please indicate your preference for confirmation:

- Call at Work
- Leave Message at home telephone no.
- Return Fax to _____

CONFIRMATION	
PT NAME	_____
DR	_____ LOC _____
DATE	_____ TIME _____