Women's Specialty and Fertility Center

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Phone: (559) 299-7700 Fax: (559) 297-9679

Patient Name: _____
(Last) (First)

DOB: _____ Phone: _____

Referring Dr. _____ Contact Person: _____

Office Phone: _____ Office Fax: _____

Insurance:

Primary: _____ Member ID: _____

Secondary: _____ Member ID: _____

Diagnosis: _____

Information Needed:

- Patient Demographics including patient email
- Insurance Card(s)
- Radiology Reports
- Pertinent Labs/Office Notes
- Authorized Referral (i.e. Key Medical, Foundation, VA, Tri-West)

Appointment Information:

Appointment Date: _____ Appointment Time: _____

Please notify your patient:

- of this appointment date and time
- to arrive at least 30 minutes prior to appointment