



Ph: 704-373-0212

Pediatric Cardiology

Fax: 704-342-5871

**Physician Appointment Request Form**

**Patient Demographics:**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Responsible Party's Name: \_\_\_\_\_ (mother/father/wife/husband/other)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Gender: Male  Female   
Interpreter Needed:  Yes  No Language: \_\_\_\_\_

**Insurance Information:**

Plan: \_\_\_\_\_ Type: PPO \_\_\_\_ POS \_\_\_\_ HMO \_\_\_\_ (Referral Sent:  Yes  No)  
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_  
NC Medicaid:  Reg.  C.A.  SC/Cov. ID # \_\_\_\_\_ Auth # (if needed) \_\_\_\_\_  
SC Medicaid:  Partners for Health  First Choice ID # \_\_\_\_\_ Auth # (if needed) \_\_\_\_\_

**Appointment Information:**

Referring Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
Dx: \_\_\_\_\_ Preferred Physician: \_\_\_\_\_  
Preferred Time Frame: \_\_\_\_\_  1<sup>st</sup> Available Appointment

**Appointment Type:**  Evaluation/Consult  Tests only \_\_\_\_\_ (please specify)

Preferred Location:  Charlotte  Fort Mill  Lake Norman  Hickory  Gastonia (pending)  
 Spartanburg (pending)  Salisbury  Rock Hill  Rutherfordton  Concord  Huntersville  Shelby

**\* Please fax any pertinent office notes, EKG's, labs, etc. along w/the Request Form to: 704-342-5871**

**Sanger Specialist to Complete:** Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Physician: \_\_\_\_\_ Location: \_\_\_\_\_  
Paperwork Mailed to Patient  Appointment scheduled by: \_\_\_\_\_