



FIRST AVAILABLE _____ **URGENT** **Translator Needed? Language** _____

- You may call or fax to schedule your New Appointment Request.
- Please fax your patient's medical records as soon as possible prior to appointment to (704) 372-3605
- Please attach insurance documentation for consult and treat.

Please print all information clearly, verify mailing address and phone number.

Patient's Full Name _____ **DOB** _____ **Sex: M** ___ **F** ___

* A demographic sheet may be sent instead of writing in patient information and insurance information.

Address _____ **SS#** _____

City _____ **State** _____ **ZIP** _____

Home (_____) _____ **Work** (_____) _____ **Cell** (_____) _____

Check One Location/Physician

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> CHARLOTTE | <input type="checkbox"/> PINEVILLE | <input type="checkbox"/> MATTHEWS | <input type="checkbox"/> MT HOLLY | <input type="checkbox"/> DAVIDSON |
| <input type="checkbox"/> Stephen Deal, MD | <input type="checkbox"/> Pascale Anglade, MD | <input type="checkbox"/> Anthony Colvin, MD | <input type="checkbox"/> Preston Purdum, MD | <input type="checkbox"/> John Clements, MD |
| <input type="checkbox"/> Michael Gaspari, MD | <input type="checkbox"/> Ronnie Cyzner, MD | <input type="checkbox"/> Ronnie Cyzner, MD | <input type="checkbox"/> MONROE | <input type="checkbox"/> Cassandra Minor, MD |
| <input type="checkbox"/> Cassandra Minor, MD | <input type="checkbox"/> Michael Gaspari, MD | <input type="checkbox"/> Stephen Deal, MD | <input type="checkbox"/> Pascale Anglade, MD | <input type="checkbox"/> Glen Portwood, MD |
| <input type="checkbox"/> Preston Purdum, MD | <input type="checkbox"/> UNIVERSITY | <input type="checkbox"/> Eric Thompson, MD | <input type="checkbox"/> Anthony Colvin, MD | <input type="checkbox"/> Barry Schneider, MD |
| <input type="checkbox"/> Eric Thompson, MD | <input type="checkbox"/> Cassandra Minor, MD | <input type="checkbox"/> CONCORD/HARRISBURG | <input type="checkbox"/> Stephen Stephenson, MD | <input type="checkbox"/> WAXHAW |
| | <input type="checkbox"/> Glen Portwood, MD | <input type="checkbox"/> Fred Fowler, MD | | <input type="checkbox"/> Anthony Colvin, MD |
| | <input type="checkbox"/> Barry Schneider, MD | | | |

Insurance Information: *(Please Complete)*

PRIMARY INS. _____ **ID#** _____

Subscriber Name _____ **Subscriber DOB** _____

Relationship to Patient _____

Carolina Access Medicaid Appointments: *(Must Be Completed)* **PCP / Group NPI #** _____

PCP / Group name listed on Carolina Access Card _____

Number of visits authorized _____ **Effective Dates** _____

REFERRING DOCTOR _____ **Contact Person** _____

Telephone # _____ **Fax #** _____

- What is the chief complaint?** *Check any that apply:*
- | | | |
|--|--|---|
| <input type="checkbox"/> EGD (must check symptoms below) | <input type="checkbox"/> GI/Rectal Bleeding | <input type="checkbox"/> Colon Cancer Screening (with office visit) |
| <input type="checkbox"/> GERD /Heartburn | <input type="checkbox"/> Dysphagia (difficulty swallowing) | <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Liver Disease/Abnormal LFT | <input type="checkbox"/> Abnormal Radiology | <input type="checkbox"/> Weight Loss <input type="checkbox"/> Abd pain |
| | | <input type="checkbox"/> Other _____ |

Every patient will be called and notified of the time and date of their appointment this business day. Thank you.

Appointment Date Confirmation: _____ **Time** _____ **Location** _____ **MD** _____

Mailed appt. card _____ **Mailed patient packet** _____