IDCOKC
Infectious Diseases Consultants
OF OKLAHOMA CITY

Request for Appointment at IDCOKC

Today's Date: _____

Patient Name: _____ M or F (circle one) Patient DOB: _____

Patient SSN: _____ Address: _____

City, State: _____ Zip: _____ Home Phone: _____

Primary Phone: _____ Cell Phone: _____

Other Emergency Contact: _____ Relationship to patient: _____

Primary Phone: _____ Secondary Phone: _____

Insurance Information: Please send a front and back copy of patient's insurance card

Referral Information:

Referring Physician: _____Phone#: _____

Office Contact Name: _____ Fax#: _____

***Diagnosis/Reason for visit:**

_____

***REQUIRED FIELD:**

NOTE: Please keep a copy of this form in your patients' chart.

Attached Insurance authorization (if required by insurance): Y or N

Attached Medical Records: Y or N

*Most recent visit notes, operative reports, any and all Imaging, all labs and cultures pertaining to reason for visit.

*Patient will not be scheduled until medical records are attached.

Once the appointment has been scheduled, we will fax this back to you with the appointment date and time.

For IDCOKC Office Use:

Appointment Date and Time: _____

Location: _____

Provider: _____