Date :_____

Arizona Kidney Disease & Hypertension Centers
AKDHC Central Appointment Scheduling
Phone: 602.351.3000 Fax: 602.200.7034

New Patient Referral Form

PATIENT INFORMATION

*__Name (Last, First, middle initial)__ *DOB Social Security #

*Street address City State ZIP Code

*Primary phone number other phone number E-mail address

*__PCP's Full Name__ Phone# Fax#

*__Referring Full Name__ Phone# Fax#

*__Patient Diagnosis__

__Labs__

*Other

*__Primary Insurance__ Phone#

*ID *Group#

Address

*__Secondary Insurance__ Phone#

*ID *Group#

Address

If insurance is under someone other than the patient:

Policy Holder Name DOB Social Security #

Relationship to Insured Employers Name:

*Required Fields

Fax completed form to 602-200-7034

Office Use Only:
Dr. # _____ Office:_____
Dr. _____ Appt Date: _____ Appt Time:_____
Follow-Up Appointment Date: _____ Time:_____