TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT SELF-REFERRAL

Date: _____

Reason for Consultation: _____

Please check physician you would like to see: **OR** ❑ **First Available Appointment**

❑ **Samer Fahoum, M.D.** ❑ **Obinna Okoye, M.D.** ❑ **Roger Gleason, III, M.D.** ❑ **John Pender, Jr, M.D.** ❑ **John Hollingsworth, II, M.D.** 1201 Fairmount Avenue, Fort Worth, TX 76104 817-335-5288 **Fax 817-338-0927**	❑ **John Burk, M.D.** ❑ **Stuart McDonald, M.D.** ❑ **Vikas Goyal, M.D.** ❑ **Harpreet Suri, M.D.** ❑ **Steven Kim, M.D.** 1521 Cooper Street, Fort Worth, TX 76104 817-336-5864 **Fax 817-336-2159**

Patient Information:

Last Name: _____ First Name/Middle Initial: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W
Cell Phone: _____ SS#: _____ DOB: _____
Email Address: _____
Employer: _____ Phone: _____

Best phone number to call, so we can contact you to make your appointment.
❑ Home ❑ Work: ❑ Cell ❑ Other Phone: _____
Best time to call: _____

Primary Care Physician: _____
PCP Phone: _____ PCP Fax: _____

Other physicians involved in your health care: _____

Provide any and all of the following, if available:

CT Chest/Abdomen Reports	Results of Recent Lab Work
Chest X-ray Reports	Recent Physician's Office Note/Report
Echocardiogram Report	Pulmonary Function Reports

Primary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's Birth Date _____ SSN _____ Sex: ☐M ☐F
Claims Mailing Address _____
_____ Phone No. _____

Secondary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's Birth Date _____ SSN _____ Sex: ☐M ☐F
Claims Mailing Address _____
_____ Phone No. _____