ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

www.arlingtonortho.com

Patient Appointment/ Consultation Request

Scheduling Phone No.: 817-375-5200
Scheduling Fax No.: 817-299-1789

Appointment Location: ☐ **Arlington** ☐ **Mansfield**

Date: _____

APPOINTMENT TYPE: ☐ **ORTHOPEDIC SURGEON** ☐ **MRI (IMAGING)**

Appointment requested as indicated below:

☐ Preferred AOA Physician: _____

☐ AOA to route to appropriate physician based on patient injury

Patient's Name: _____ DOB: _____

Address: _____ City: _____ St: _____ Zip:_____

Patient Daytime Phone #: _____ Evening Phone #: _____

Reason for Consultation: _____

Diagnosis (ICD-9, if available): _____

Consulting Physician: _____

Consulting Physician Office #: _____ Fax #: _____

Appointment Requested: ☐ 1st Available ☐ Immediately

Please fax a copy of the following information with this form to schedule a patient appointment:

- Patient's demographic/insurance information
- Updated history and physician report
- Diagnostic Imaging / Radiology reports (MRI, CT, X-Ray)
- MRI Orders
- Other pertinent patient information

Special Instructions:

☐ AOA to schedule the appointment and contact the patient directly.

☐ AOA to schedule the appointment and fax appointment information to the following:

Contact: _____ Fax#: _____

☐ Other instructions: _____

FOR AOA USE ONLY:

Patient Appointment Scheduled with Dr. _____ Backline Phone: _____

Patient Appointment Date: _____ Time: _____