Medical Appointment Form

Participant Name: _____

Type of Appointment: _____ Date/Time of Appointment: _____

Date of Birth: _____ Social Security Number: _____

Medicare/Medicaid Number: _____

Diagnosis: SEE PHYSICIAN'S ORDERS (attached)

Current Medications: SEE PHYSICIAN'S ORDERS (attached)

Allergies: _____

Primary Care Physician: William Fosmire, MD, Laradon Medical Services Department

FOR PHYSICIAN/MEDICAL PERSONNEL DOCUMENTATION ONLY BELOW THIS LINE

Please evaluate and recommend treatment for the person listed above:

Diagnosis: _____

Treatment, Orders or Comments*: _____

Next Visit/Follow Up: _____

_____

Physician or Medical Practitioner Signature

_____

Printed Name

_____

Date

Please fax dictation, including test results, to PCP/Laradon Medical Services Dept. 303-244-1049

Did your doctor shake your hand?

Did your doctor ask how you are doing?

Did your doctor call you by name?

Have you been given a choice of which doctor you see?

Do you want to keep seeing this doctor?