



## Appointment Request Form

New Patient \_\_\_\_\_  
Existing Patient \_\_\_\_\_

### Patient Information

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cellular (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_  
 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed

If this appointment is for a minor or for an individual for whom you have guardianship, please provide your name \_\_\_\_\_, relationship \_\_\_\_\_  
 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ and date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_.

### Select a Provider

First available appointment  Only wish to see a physician (not a nurse practitioner)

**Family Practice**

Ronald N. Skufca, D.O.  Aurelio Ibarra, M.D.  
 John R. Richmond, M.D.  Maria Ramirez, FNP  
 Erik Maynard, M.D.  SanDee Harris, FNP  
 Kenneth Baird, M.D.

**Obstetrics & Gynecology**

Nathan Truett Thomas, M.D.

Please be advised that all providers do not work all day every day. Therefore, we will attempt to accommodate you based on your selection.

### Select Best Time and Day for your Appointment

First Available Appointment

**Please provide your 1<sup>st</sup> choice for the day of week for your appointment**

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

**Please provide your 2<sup>st</sup> choice for the day of week for your appointment**

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

**Please provide your 1<sup>st</sup> choice for the time range which would best suit your schedule.**

8 am – 10 am  10 am – 12 pm  12 pm – 2 pm  3 pm – 5 pm  5 pm – 8 pm

**Please provide your 2<sup>st</sup> choice for the time range which would best suit your schedule.**

8 am – 10 am  10 am – 12 pm  12 pm – 2 pm  3 pm – 5 pm  5 pm – 8 pm

### Briefly describe for what you will be seen

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Appointment Request Form (continuation)

In the event we have a scheduling conflict due to the provider not being available on the dates and/or times that you requested, we will contact you to discuss other options.

Please specify how you would like to be contacted with your appointment and/or to discuss alternative dates/times if needed.

- Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Cellular (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- E-Mail \_\_\_\_\_

How did you hear about HealthCareClinics?

- Friend
- Internet
- Mailer/Postcard
- Relative
- Dallas Business Journal
- Other Physician
- Drive by
- D Magazine
- Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR OFFICE USE ONLY**

Appointment Request Form received on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ am \_\_\_\_ pm By \_\_\_\_\_

Patient contacted with an appointment on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ am \_\_\_\_ pm By \_\_\_\_\_

Contact Successful \_\_\_ Yes \_\_\_ No

2<sup>nd</sup> Attempt to Contact the patient was made on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ am \_\_\_\_ pm By \_\_\_\_\_

Contact Successful \_\_\_ Yes \_\_\_ No

3<sup>rd</sup> Attempt to Contact the patient was made on \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ am \_\_\_\_ pm By \_\_\_\_\_

Contact Successful \_\_\_ Yes \_\_\_ No