Huron Gastro
Center for Digestive Care
Appointment Request Form

Fax: (734) 714-3077

www.hurongastro.com

Date: ________________________

Include patient demographic sheet or complete patient information below:

Patient Name: ________________________ **Patient DOB:** ____________

Address: ________________________**City:** ______________**State:** ____

Gender: ________ **Requesting Provider:** ________________________

Home Phone: __________________ **Other Phone:** __________________

Primary Insurance: ________________ **Insurance Number:** ______________

Secondary Insurance: ________________ **Insurance Number:** ____________

Type of Visit:

____ **New Patient Referral** (Treatment & management of a **confirmed** diagnosed problem/condition)

____ **Established Patient Referral** (Follow-up on an existing problem/condition)

Procedure:

___**Colonoscopy**
___**Gastroscopy**
___**Sigmoidoscopy**
___**Other**

Reason for Visit: ________________________

Additional Visit Information
Please **list** or **attach** all tests, relevant to the appointment request, performed and/or treatments attempted (including medications.)

If you would like to request your appointment via the Internet, please visit our website at www.hurongastro.com .

Phone: (800) 772-4659 or (734) 434-6262