FETAL CARE CENTER
DALLAS

Pediatric Cardiology Intake Form

Dr. Reenu Eapen, MD **Dr. Maytham Al-Kubaisi, MD**

Date of Request:_____/_____/ _____

Urgency (Please mark):_____24-48 hours _____1 week _____Next Available

Referring Provider/Hospital: _____

Referring Providers Phone: _____ Fax: _____

Patient Name: _____

DOB _____ Age_____

Address: _____City: _____ State: _____ Zip:_____

Telephone Number_____

Parent's Name 1: _____ Parent's Name 2: _____

Insurance Company: _____ Insurance Phone #:_____

Subscriber ID: _____ Group #:_____

Policy Holder Name: _____ DOB:_____/_____/_____ Relationship: _____

Pediatric Echo Indications/Diagnosis: _____

Desired Location (Please mark):

□ MEDICAL CITY DALLAS, 7777 FOREST LANE, STE C-742, D, TX 75230: P) 972-566-5600; F) 972-566-5680
□ DOWNTOWN DALLAS, 3801 GASTON AVE, STE 250, DALLAS, TX 75246: P) 214-824-9600; F) 214-824-9601
□ ARLINGTON, 515 W. MAYFIELD, STE 240, ARLINGTON, TX 76014: P) 972-566-5600; F)972-566-5680
□ ABILENE, 1850 HICKORY ST, STE 200A, ABILENE, TX 79601: P) 325-670-6690; F) 972-566-5680
□ LONGVIEW, 1009 NORTH FOURTH STREET, STE B, LONGVIEW, TX 75601: P) 214-824-9601; F) 214-824-9601
□ MCKINNEY, 5236 W UNIVERSITY Dr, STE 3700, MCKINNEY, TX 75071: P) 972-566-5600; F) 972-566-5680
□ PLANO, 1600 COIT RD, STE 210, PLANO, TX 75075: P) 972-566-5600; F) 972-566-5680

- **Please fax demographics and medical records to 972-566-5680**

Initials of person filling out request: _____ Date: _____