California Diabetes and Hormone Specialist, Inc
301 W. Huntington Drive, Suite 212
Arcadia, CA 91007
Phone: (626)821-5300
http://www.cadhs.com

Irene T. Gaw Gonzalo, MD

-CONFIDENTIAL-

INITIAL PATIENT FORM

Patient Information

MR# ______________________ Date: ______________________

Last Name: ______________________ First Name: ______________________ M.I.: ______

Date of Birth: ______________________ Referred by: ______________________

Diagnosis Code

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New Patient Visit (Without Referral) 3/3	Established Patient Visit 2/3
Consultations (Requested by MD) 3/3	Confirmatory Consultation 3/3
Team Conference	Prolonged Services
Preventive Medical Evaluation	Patient Training
OFFICIAL SURGICAL PROCEDURES	**OTHER**

COPAY : ______