



**MIAMI  
CHILDREN'S  
HOSPITAL®**

Phone: 305-663-8413  
Fax: 305-662-8305

New Appointment  Reschedule

**MCH Use Only:**

Location: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

Arrival Time: \_\_\_\_\_

Scheduled by: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Confirmation Number: \_\_\_\_\_

**Central Scheduling Appointment Form**

Procedure:		
Specifications:	Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Additional:	
Diagnosis:		
Patient:	Name:	
	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Referring Physician:	Name:	
	Phone:	
	Fax:	
Primary Care Physician:	Name:	
	Phone:	
Patient's Address:	Street:	
	City:	
	State:	Zip Code:
Phone Numbers:	Primary:	
	Secondary:	
Mother:	Name:	
	Date of Birth:	
Father:	Name:	
	Date of Birth:	
Insurance:	Company:	
	Phone Number:	
	Policy Number:	
	Group Number:	
Subscriber:	Name:	
	Date of Birth:	
Preferred Appointment:	Date:	
	Time:	
Form Completed By:		