

J. MICHAEL PUTMAN, M.D. & ASSOCIATES
REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY
ADVANCED GYNECOLOGIC ENDOSCOPY

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(214) 887-8244 FAX

PATIENT NAME: _____ APT. DATE: _____ WITH DR _____

Dr. Putman would appreciate your completing the following:
Please include all information.

First and last name of the physician who referred you to our practice:

Address: (Include zip code)

Phone Number:

Fax Number:

If you have the type of insurance that requires a primary care physician (the doctor's name on your insurance card), please complete the following:

Name of Primary Care Physician:

Address:

Phone Number:

Fax Number:

Number of visits authorized: _____ *(Please try to get this information)*