MINNESOTA UROLOGY

# Appointment Scheduling Request Form

Please complete the following information when requesting an appointment by fax.
Please check the box of your location preference and fax your request to the attention of **Appointment Scheduling**. Thank you for your cooperation in providing the information below.

☐ **Fridley**
Fax: 651-999-6832

☐ **Maplewood**
Fax: 651-999-6831

☐ **Plymouth (Metro Div)**
Fax: 651-999-6834

☐ **St. Paul 400**
Fax: 651-999-6910

☐ **Woodbury**
Fax: 651-999-6995

☐ **Edina**
Fax: 952-922-1623

☐ **Robbinsdale**
Fax: 763-520-7776

☐ **Plymouth (UA Div)**
Fax: 763-270-3389

Patient's Name: _____ Male ☐ Female ☐

Date of Birth: _____ Soc. Sec. #: _____

Responsible Party (If Patient is a Child): _____ Male ☐ Female ☐

Responsible Party's Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Referring Doctor: _____

Clinic Name: _____ Clinic Phone: _____

Clinic Contact: _____ Clinic Fax: _____

Interpreter Needed? Yes ☐ No ☐ If yes, what language? _____

Urology Diagnosis: _____

Date: _____ Facility: _____

Types of Films: _____

Insurance Name: _____

Insurance ID# _____ Insurance Group#: _____

*****Referring clinic must contact the patient with the appointment information*****

Appointment Date: _____ Time: _____

Location: _____ Physician: _____