



Fertility Center of Dallas
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Reproductive Endocrinology and Infertility
Advanced Gynecologic Endoscopy

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(214) 887-8244 (F)

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

Fertility Center of Dallas 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)