Candida Fink MD

4 Stanton Circle
New Rochelle NY 10804
Phone 877-534-1090 Fax 914-560-2106

APPOINTMENT REQUEST

Please enter all requested information and fax your appointment request to our office.

Your Name: ____

Patient's Name: ____

Date of Birth (MM/DD/YYYY): ______ / ______ / __________

Please select the type of appointment you need. Choose only one.

- ☐ **30 minutes**
- ☐ **45 minutes**
- ☐ **1 hour**
- ☐ **90 minute child intake**
- ☐ **60 minute adult intake**

When do you need this appointment? ________________________________

Which times are best for you? Mark all that apply. ***After school appointments are scarce; please book in advance***

- ☐ **Mondays 11:30-3:30**
- ☐ **Tuesdays 12:30-2:00**
- ☐ **Tuesdays 3:00-7:00**
- ☐ **Wednesdays 11:30-1:00**
- ☐ **Wednesdays 2:00-6:00**
- ☐ **Thursdays 11:00-12:30**
- ☐ **Thursdays 1:00-4:30**

Home Phone: ____

Work Phone: ____

Cell Phone: ____

Email Address: ____