90-250 APPENDIX F. FORM 11-66 HHSA

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
GREE APPOINTMENT SCHEDULE

CLINIC_____ FAMILY RESOURCE CENTER_____
PHONE NO._____ PHONE #_____
CONTACT_____
FAX NO._____
APPOINTMENT DAY/DATE_____/_____

Time	Patient's Name	ZIP	SSN # and DOB	Case No.	HHSA Appt. Date and Wkr. No.	CMS Cert.	Patient's Statement