KOUSAY AL-KOURAINY, M.D.
IGNACIO ITURBE, M.D.
480 Fourth Ave, Suite 409
Chula Vista, CA 91910
619-425-2080

Date:_____

Dear Patient:_____

You are scheduled for a consultation with Doctor _____

The date and time of your appointment is_____

Enclosed herewith are new patient registration forms, please fill these forms out completely and bring them with you to your appointment. <u>If the forms are not completed you may have to wait or be rescheduled.</u> If you have any questions please feel free to call our office.

Thank you,