KNOXVILLE INSTITUTE OF DERMATOLOGY

FORMERLY ANDERSON AND RAHMAN DERMATOLOGY

APPOINTMENT REQUEST FORM

PATIENT NAME: ____ DOB: ______________________

INSURANCE: ____________________ SEX: __________________
SS#________________________

ADDRESS: ______________________________ CITY, STATE, ZIP:
____

PRIMARY PHONE: ________________________ SECONDARY PHONE:

____

EMAIL ADDRESS: _______________________________________

CHIEF COMPLAINT/REASON FOR REFERRAL:

____

PREFERRED LOCATION:

☐ MAIN OFFICE (KNOXVILLE-BEARDEN)
6516 KINGSTON PIKE
KNOXVILLE, TN. 37919

☐ SATELLITE OFFICE (LENOIR CITY)
1018 HIGHWAY 321 NORTH
LENOIR CITY, TN. 37771

PRIMARY CARE PHYSICIAN:

____

REFERRING PHYSICIAN:

____

REFERRING PHYSICIAN PHONE: __________________________ FAX:
____

THE **FIRST AVAILABLE APPOINTMENT** AT THE PATIENT'S PREFERRED LOCATION WILL BE SCHEDULED;
IF **STAT APPOINTMENT IS REQUESTED PLEASE CALL** OUR OFFICE AT (865) 450-9361.

APPOINTMENT IS SCHEDULED:

DATE: ___________________________ TIME: ____________________

ELIZABETH ANDERSON, MD **QUYN RAHMAN, MD**

ADAM WRIGHT, MD

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KNOXVILLE INSTITUTE OF DERMATOLOGY

REFERRING OFFICE IS RESPONSIBLE FOR NOTIFYING THE PATIENT OF THEIR APPOINTMENT DATE AND TIME AND PRACTICE INFORMATION. THE PATIENT SHOULD ARRIVE 10 MINUTES EARLY OR PRINT OFF NEW PATIENT PAPERWORK AT WWW.DERMATOLOGYKNOXVILLE.COM.

PLEASE FAX ONLY OFFICE NOTES PERTAINING TO THE REFERRAL ISSUE, PRIOR TO THE SCHEDULED APPOINTMENT. FAX: (865) 450-9362