



KNOXVILLE INSTITUTE  
OF  
DERMATOLOGY

## Appointment Request Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Chief Complaint/Reason for Referral: \_\_\_\_\_

Consult Requested With: \_\_\_\_\_

Acceptable to Schedule With a Physician Assistant or Nurse Practitioner:  Yes

Preferred Location:

- |                                                                                        |                                                                                                |                                                                                       |                                                                                                      |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Knoxville</b><br>6516 Kingston Pike<br>Knoxville, TN 37919 | <input type="checkbox"/> <b>Lenoir City</b><br>1018 Highway 321 North<br>Lenoir City, TN 37771 | <input type="checkbox"/> <b>Tellico Village</b><br>202 Dohi Drive<br>Loudon, TN 37774 | <input type="checkbox"/> <b>Jefferson City</b><br>380 West Broadway Blvd<br>Jefferson City, TN 37760 |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

Referring Physician: \_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Appointment is scheduled:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Note: \_\_\_\_\_

- |           |                        |                    |                     |
|-----------|------------------------|--------------------|---------------------|
| Provider: | Elizabeth Anderson, MD | Quyn Rahman, MD    | Anne Allen, MD      |
|           | Joshua Bakke, MD       | Callyn Henry, PA-C | Jordan Ridder, PA-C |
|           | Lindsey Best, FNP-BC   | Kegan Reilly, PA-C |                     |

Referring office is responsible for notifying the patient of their appointment date and time. The patient should arrive 10 minutes early or can print forms online at [www.dermatologyknoxville.com](http://www.dermatologyknoxville.com).

Please fax office notes, demographics, and insurance card prior to the scheduled appointment. FAX: (865) 450-9362