DAK | Dermatology Associates of Knoxville

An Affiliate of Anne Arundel Dermatology

Patient Appointment Request

Please complete this form for each individual patient you are referring and either EMAIL to tharris@dermaknox.com or FAX to 865.205.5598.

Please allow 24 hours for appointment confirmation.

PATIENT'S NAME:	**DATE OF BIRTH:**	
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
INSURANCE:		
PATIENT PHONE NUMBER:	**PREFERRED APPOINTMENT LOCATION:**	
REFERRING PROVIDER NAME & PHONE NUMBER: **How would you like us to confirm the appointment?** **EMAIL ADDRESS:** **FAX #**	**PREFERRED APPOINTMENT DATE & TIME:** **REASON FOR APPOINTMENT:**	