University Surgical Associates

Patient Appointment Form – Dayton & Decatur Offices

Dr. Craig Swafford & Dr. Benjamin Kellogg

Date: _____ Referring Physician Name: _____

Office Contact: _____ Office Phone: _____ Office Fax: _____

Office Email Address: _____

USA Physician Requested: _____

Patient Name: _____

If Child, Name of Parent/Guardian: _____

Patient Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Male/Female: _____ SSN: _____

Insurance: _____

Group #: _____ Subscriber ID#: _____

Diagnosis, Test and/or Symptoms: _____

Day/Time Patient is Available for Appointment: ☐M ☐T ☐W ☐Th ☐F ☐Mornings ☐Afternoons

USA Office Preferred: _____

Along with this form, please fax: demographics, office notes, tests, studies, ultrasounds, lab results and legible copy of insurance card(s).

Fax to: (423) 775-1981

Thank you for your referral!

USA will contact the patient with the appointment information below.

Appointment Date:_____ Appointment Time: _____

USA Physician: _____ USA Office: _____

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