Patient Appointment Form

Patient appointment requests submitted after 4:30 PM will not be scheduled until the following business day.

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) 778-5177

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THIS AREA TO BE COMPLETED BY USA STAFF – IT IS USA'S RESPONSIBILITY TO CONTACT PATIENT WITH APPOINTMENT INFORMATION BELOW

Appointment Date:________________________ Appointment Time: ________________________

USA Physician: ____________________________________ USA Office: ________________________

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