



New Appointment Request Form

Please Fax All requests to 865-286-9967

We will contact the patient, set up the appointment, and fax a notification to your office of appointment date and time.

Referring Practice:	Referring Provider:	
Date of referral:		
Patient Last Name:	First:	MI
Home Phone:	Cell Phone:	
Patient Date of Birth:	Insurance Type:	

** If the patient is a minor, please fill in the following information.*

Parent/Guardian Last Name:	First:	MI
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<p>Please check requested specialty services:</p> <p><input type="checkbox"/> Allergy/Immunology</p> <p><input type="checkbox"/> Sleep Medicine</p> <p><input type="checkbox"/> Both</p>	<p>Comments:</p>
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**If you have questions, please call: Keeton Clinic, PLLC: 865-286-9977 or
Dr. Keeton's cell phone: 352-283-6682**

Important Notice: This message is intended only for the use of the entity to which it is addressed. It contains information that is privileged, confidential, and exempt from disclosure under law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return the original message to us via the United States Postal Service. Thank you.