



669 West 900 North  
SLC, Utah 84054

Toll Free 888.222.2956  
Fax 801.294.1401

## New Physician Form

Physician Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_  
 DEA \_\_\_\_\_ License \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Email \_\_\_\_\_

**Pharmacy Preferences:**

Account Set up, Instascript    Yes  No   
 Custom Prescription Pads    Yes  No   
 Billing  
 Bill Physician       Bill Patient

**Laboratory Testing Preferences:**

How would you like to receive your lab results?  
 Fax:     Email:     InstaScript:   
 Billing  
 Bill Physician       Bill Patient   
 Draw Kits  
 Have in office     Send directly to patient

**Credit Card Information**

Visa       Master Card       Discover       American Express   
 Number \_\_\_\_\_      Expiration Date \_\_\_\_\_  
 Name on Card \_\_\_\_\_  
 Billing Address \_\_\_\_\_  
 City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_      Same as above

Notes or special instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_