

NEW CLIENT INFORMATION FORM

Client Information

Client Name*:			
Client Name 2:			
Address 1:			
Address 2:	(optional)		
City:	State:	Zip:	
Primary Contact:			
Secondary Contact:			
Phone:		Fax:	
E-mail:	Secondary Phone:		

* note: minimum of one person must be granted access to the GTC LIS

Billing Information:

Payable-Name Con:	
Billing Phone:	
Billing e-mail:	

Reports to be received by

<input type="checkbox"/> Electronic*:	
<input type="checkbox"/> Fax Number:	
Report copy(s) to:	

* note: minimum of one person must be granted access to the GTC LIS

Authorized Ordering Physician Details

Physician Name			
Address 1:			
Address 2:	(optional)		
City:	State:	Zip:	
Phone:		Fax:	
E-mail:	Secondary Phone:		
License Number		Type:	

