



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: _____