



**PROVIDER / CLIENT INFORMATION FORM:**

*This information will only be used internally and kept strictly confidential*

Request Stamp       Office Location Change       Additional Office Location

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Yr                      Month                      Day

Physician Name	<i>Surname</i>	<i>First</i>	<i>Middle</i>
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PRACID#	
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Medical Specialty	
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Building/Clinic Name	
Address	
City	
Province	
Postal Code	
Is this your primary location? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, please indicate your primary office location?

Office Phone	
Office Fax	
Home Phone	
Home Fax	
Pager/Cell Phone Number	
Answering Service Number	

Special Instructions for contacting physician with results	
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<b><i>Shaded Area for CLS Use Only</i></b>	Client #		Provider #	
	DRT#		Provider Help Info	
	Sequence #			

**FAX TO:                      DATA MAINTENANCE                      (403)770-3235**