

Primary Care Physician Information

This information is needed in order to bill your insurance company for your visit. If we do not obtain the correct information the bill will be placed as the patient's responsibility.

Medical Dr.'s Name: _____

Clinic Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Signature: _____ **Date:** _____

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