UMIAMI Acute Phase Protein Laboratory
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NEW CLIENT FORM ACCT

NAME OF CLINIC	
NAME OF DOCTOR	
CONTACT NAME FOR SUBMISSIONS	
CONTACT NAME FOR BILLING	
ADDRESS	
BILLING ADDRESS (IF DIFFERENT)	
PHONE	
FAX	
EMAIL (FOR REPORTS)	
EMAIL (FOR BILLING STATEMENTS. IF ELECTED, STATEMENT WILL NOT BE SENT BY REGULAR MAIL)	
HOW DO YOU WANT YOUR REPORTS?	
PASSWORD FOR ON-LINE ACCESS	
Where did you hear about our services?	

FOR LAB USE ONLY (INITIALS/DATE):

ADDED TO VADDS	
ADDED TO EXCEL	
START UP PACKAGE	
CLIENT TYPE	