PRO IMAGING, INC.

INFORMATION SHEET FOR NEW PHYSICIANS

NAME:

CLINIC NAME:

ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE NUMBER:

FAX NUMBER:

LICENSE NUMBER:

NPI NUMBER:

OFFICE HOURS:

CONTACT PERSON:

PREFERENCE TO REC. REPORTS:

1. **Email (email address)__________________________________**
2. **Hardcopy____**
3. **Faxed____**
4. **Combination of more than one__________________________**

Please fax to 772-600-7827 after completion.

Thank you , Office Staff