



**NORTHEAST**  
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 Brooklyn, NY 11218  
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**SOUTHEAST**  
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## CLIENT SETUP FORM

- NEW CLIENT  
 EXISTING CLIENT UPDATE

NORTHEAST ACCOUNT #: \_\_\_\_\_

SOUTHEAST ACCOUNT #: \_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_ NPI# \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

REFERENCE LABORATORY ACCOUNT #: \_\_\_\_\_ (ATTACH SAMPLE REQUEST FORM)

**Emergency Contact (for Critical Results):** \_\_\_\_\_ **Emergency Phone Number:** \_\_\_\_\_

	OFFICE HOURS	PICK UP TIME	CALL FOR PICK UP	
MONDAY	TO	TO	LAB CLIENT AUTO	PRIMARY CONTACT:
TUESDAY	TO	TO	LAB CLIENT AUTO	TELEPHONE:
WEDNESDAY	TO	TO	LAB CLIENT AUTO	
THURSDAY	TO	TO	LAB CLIENT AUTO	SECONDARY CONTACT:
FRIDAY	TO	TO	LAB CLIENT AUTO	
SATURDAY	TO	TO	LAB CLIENT AUTO	TELEPHONE:
SUNDAY	TO	TO	LAB CLIENT AUTO	

ADDITIONAL DOCTORS W/NPI #:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOTES/REQUESTED PROFILES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REPORTING:**  
 FAX  
 HARD COPY  
 WEB RETRIEVAL

**REQUISITION SELECTION:** (Check all required forms and supplies setup)

- |                    |               |               |               |                  |
|--------------------|---------------|---------------|---------------|------------------|
| CLINICAL TESTING   | ALLERGY       | TOXYCOLOGY    | CGX           | PHARMA GX        |
| GENERAL PATHOLOGY  | DERM/PODIATRY | GYN PATHOLOGY | GYN INFECTION | BREAST PATHOLOGY |
| UROLOGIC PATHOLOGY | GI PATHOLOGY  | ORAL PATH     | EYE PATHOLOGY |                  |

CLIENT FORM SETUP BY: \_\_\_\_\_ CLIENT SERVICE REP: \_\_\_\_\_