Anderson Healthcare

PROVIDER CONTACT INFORMATION

Please provide your contact numbers below, in order of preference, for staff to contact you.

NAME:		
CONTACT NUMBER IN ORDER OF PREFERENCE	**TYPE OF NUMBER**	**SPECIAL INSTRUCTIONS**
1.	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	
2.	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	
3.	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	
4.	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	
5.	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	
Contact Number for E-prescribing Clarification	☐ Cell ☐ Home ☐ Pager ☐ Office ☐ Exchange	

PRIMARY OFFICE ADDRESS:	PRIMARY OFFICE PHONE/FAX/EMAIL:
_____	OFFICE #:_____
_____	FAX #:_____
_____	EMAIL:_____

_____ _____

Provider Signature **Date**

_____

Printed Name