HolyCross
Urgent Care
A Member of Trinity Health

RIO VISTA
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NEW CLIENT INFORMATION
SERVICES REQUESTED

Company Name: _____Todays Date: _____

Company Address: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____Position at Company: _____

Cell Number: _____ Email: _____

Send reports via: □ Fax   □ E-Mail   □ Mail   □ Other _____

Billing Information:

Billing Address: _____

Accounts Payable Contact: _____

Worker's Comp Information:

Worker's Comp Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Policy Number: _____

Services Requested:

Physical Examination Type: _____

Additional Test: □ Other _____

For Office Use Only!

Clinic Location_____   Patient MRN_____

Please email this information to: robert.howellrose@trinity-health.org