NEW ACCOUNT FORM

WellHealthLabs DALLAS

Practice Information

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Physician's Name (M.D., D.O., CRNP.): _____

Physician's NPI: _____

Office Contact Name: _____

Office Contact Phone #: _____

Office Contact Email: _____

Additional Providers

Physician's Name: _____, _____, _____

Physician's NPI: _____, _____, _____

Physician Signature

I _____ attest that the below signature is indeed my own.
Physician's Name(s)

X_____ X_____
Physician's Signature Physician's Signature

X_____ X_____
Physician's Signature Physician's Signature

Laboratory Services

- ☐ PCR Molecular Diagnostics
  - Covid-19
  - Monkeypox
  - RPP
  - Wound
- ☐ Urine Wellness
  - Toxicology
  - UTI
- ☐ Genetic Testing

Specimen Reporting

Portal Email: _____
Portal set-up instructions will be sent to this email address

Portal Contact: _____

350 Westpark Way, Suite 100B
Euless, TX 76040
Phone: 817-786-8005 Fax: 346-275-1700
www.wellhealthlabs.com

FOR ALL NEW ACCOUNTS, WE MUST RECEIVE CONFIRMATION OF THE ORDERING PHYSICIAN'S SIGNATURE. PLEASE HAVE THE ORDERING PHYSICIAN SIGN OFF AND ACKNOWLEDGE THEIR SIGNATURE ON A PRESCRIPTION PAD.

NEW ACCOUNT FORM

Additional Facility Locations

WellHealthLabs DALLAS

Practice Information

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Physician's Name (M.D., D.O., CRNP.): _____

Physician's NPI: _____

Office Contact Name: _____

Office Contact Phone #: _____

Office Contact Email: _____

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Physician's Name (M.D., D.O., CRNP.): _____

Physician's NPI: _____

Office Contact Name: _____

Office Contact Phone #: _____

Office Contact Email: _____

Physician Signature

I _____ attest that the below signature is indeed my own.

Physician's Name(s)

X_____

Physician's Signature

X_____

Physician's Signature

X_____

Physician's Signature

X_____

Physician's Signature