AIS HealthCare™ *Patient. Care. Trust.™*

Provider Profile Form

Clinic Name: _____

Are you a hospital? ☐ Yes ☐ No **Are you affiliated with a hospital?** ☐ Yes ☐ No

Provider(s)

NAME	EMAIL	DEA#	NPI#
NAME	EMAIL	DEA#	NPI#
NAME	EMAIL	DEA#	NPI#
NAME	EMAIL	DEA#	NPI#

Clinic Address(es):

LOCATION NAME	LOCATION NAME	LOCATION NAME
ATTENTION	ATTENTION	ATTENTION
ADDRESS	ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
PHONE	PHONE	PHONE
FAX	FAX	FAX
BACK PHONE LINE	BACK PHONE LINE	BACK PHONE LINE
EMERGENCY CONTACT	EMERGENCY CONTACT	EMERGENCY CONTACT
EMERGENCY PHONE	EMERGENCY PHONE	EMERGENCY PHONE

Clinic Contact(s) (Please check the box if you would like to receive):

NAME	EMAIL			
NAME	EMAIL	☐ ORDER CONFIRMATION	☐ ORDER FORMS	☐ PORTAL LOGIN
NAME	EMAIL	☐ ORDER CONFIRMATION	☐ ORDER FORMS	☐ PORTAL LOGIN
NAME	EMAIL	☐ ORDER CONFIRMATION	☐ ORDER FORMS	☐ PORTAL LOGIN
		☐ ORDER CONFIRMATION	☐ ORDER FORMS	☐ PORTAL LOGIN

Business Hours, Days Closed: _____

Preferred Delivery Days? ☐ Yes ☐ No **If Yes:** _____

Notes: _____

AIS Sales Mgr: _____

Phone Number: _____ **Email:** _____

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