



P.O. Box 1315 Waianae, Hawaii 96792
(808) 988-2188

SUBSCRIBER FACT SHEET

Subscriber's Name: _____ Specialty: _____

Company or Group Name: _____

Physical Address: _____ City: _____ ZIP: _____

Billing Address: _____ City: _____ ZIP: _____

Office Phone #: _____ Fax #: _____ Cellular#: _____

Pager#: _____ Home Phone#: _____ Other#: _____

Email Address for SMS Messaging _____

Mobile Provider (check one): Verizon T-Mobile AT&T Other: _____

Office Hours:

Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Lunch Hours: _____

Calling Instructions: (How to reach you during office hours & after office hours)

Do you prefer calling home, cell, texting, email or paged first? (i.e., During office hours: call the office, after hours call cell first then home)

During office hours: _____

After Hours: _____

If there is more than one doctor in the office subscribing, please fill out a separate sheet for each doctor in the office and staple them together. A group rate will be assigned based on the number of doctors in the office.

Signature: _____ **Date:** _____

Office use only:

Date Received: _____ **Service Date to Begin:** _____ **Billing Cycle:** _____

Please sign, date, and send a copy to: Doctors Answering Service P.O. Box 1315 Waianae, HI 96792