



Residence Confirmation

Date: _____ Patient Name: _____

This is to confirm that the above-mentioned patient lives with me and can receive mail at the following address:

Address: _____

Apt. #: _____

City, State, Zip: _____

He/she contributes \$ _____ towards rent each month.

He/she lives here: _____ 100% of the time
 _____ 50-99% of the time
 _____ Less than 50% of the time

Printed Name: _____

Signature: _____

If Doctors Care has questions, how may we contact you?

Phone: _____

E-mail: _____

Fax: _____