DispatchMD: Patient Registration

Basic Information

Full Name: _____ Sex (circle)- Male Female

Primary Phone: _____ Home Mobile Work (circle)

Email: _____ SSN: _____/_____/_____

Address: _____ DOB: _____/_____/_____

City: _____ State: _____ Zip Code: _____

Driver's License #_____ DL State: _____

Emergency Contact

Full Name: _____

Relationship to Contact: _____

Primary Phone: _____ Home Mobile Work (circle)

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Method Of Payment

Please circle one: Cash Credit/Debit Card HSA/FSA Card

If membership is through employer, please list business: _____

DispatchMD is a Fee-For-Service/Direct Primary Care Medical Practice and payment is required at time of service. We do not accept any insurances but will work with your insurance for outside diagnostics.

Insurance Company: _____ Enrollee ID: _____

Name of insured: _____ Group #: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Address: _____