

MED-E-TAINER
*******PATIENT SUBSCRIPTION FORM**

Physician: _____

Please complete the information below and mail with payment to:

Primary Care Consultants
12700 Southfork Road, Suite 280
St. Louis, Missouri 63128
Attention: Med-e-Tainer

Name:

(last)

(first)

(middle initial)

Address:

City, State, Zip:

Date of birth:

- -

mm-dd-yyyy (Example: 06-21-2001)

Phone number:

- -

Health/Insurance plan:

E-mail address:

Enter your e-mail address in the format name@domain.com (please print clearly)

Last 4 digits of your Social Security Number:

Subscription Type:

Single - \$50.00/yr

Family - \$25.00/yr each additional member - *(please turn this sheet over to add additional family members information)*

Method of Payment:

Enclosed is my check

(make check payable to Primary Care Consultants)

Please charge my *(circle one)*

VISA

MasterCard

Card Number _____

Exp. Date:

/

Please complete the information below for additional family members.

Note: Family members must be established patients and living in the same household.

Name: _____
(last) (first) (middle initial)

Date of Birth: - - **Last 4 digits of SSN:**

Health/Insurance plan: _____

E-mail Address: _____

Doctor: _____

Name: _____
(last) (first) (middle initial)

Date of Birth: - - **Last 4 digits of SSN:**

Health/Insurance plan: _____

E-mail Address: _____

Enter e-mail address in the format *name@domain.com* **(please print clearly)**

Doctor: _____

Name: _____
(last) (first) (middle initial)

Date of Birth: - - **Last 4 digits of SSN:**

Health/Insurance plan: _____

E-mail Address: _____

Enter e-mail address in the format *name@domain.com* **(please print clearly)**

Doctor: _____

Name: _____
(last) (first) (middle initial)

Date of Birth: - - **Last 4 digits of SSN:**

Health/Insurance plan: _____

E-mail Address: _____

Enter e-mail address in the format *name@domain.com* **(please print clearly)**

Doctor: _____