HICKORY MEDICAL

DIRECT PRIMARY CARE, LLC

Member Registration Form

This form can be completed in paper form or online. It should be completed for each family member. To become a member, in addition to this form, you need to complete a Release of Records Form, the Membership Contract, and the Medicare Private Contract (if Medicare eligible).

Name: _____ Date of Birth: _____

Gender: Male Female

Email: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

_____

_____

How did you hear about us? _____

Membership fee

□ Adult: $39 joining fee, $39/month membership fee, $20 visit fee

□ Child (under 18 with parent): $19 joining fee, $19/month membership fee, $20 visit fee

Payment

□ Automatic payment from bank account (ACH) - include voided check

□ Credit Card:

□ Visa □ MasterCard

Name: _____

Card Number: _____ Exp: _____

CVC code (from back of card): _____

Signature: _____

When complete, paper form can be faxed to (937) 404-2428 or mailed to Hickory Medical Direct Primary Care, 208 West Columbus Avenue, Bellefontaine, Ohio 43311.