MANDATORY PRACTICE ENROLLMENT FORM

regenr8pro
Delivering Personalized Wellness

Pro ID# of Rep/Group: _____

Health Consultants Name: _____ Today's Date: _____

PRACTICE INFO:

Practice ID#: _____

Name: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Shipping Address: (If Different from Billing) _____ City: _____ State: ____ Zip: _____

Specialty: _____ Years At This Location: _____

Patients Seen Monthly: _____ New Patients Seen Monthly: _____

Desired Web Handle: _____

Example: www.Regenr8.pro/reports-**your web handle**

Reports Portal Password _____

PROVIDER INFO:

Name:	_____	Cell:	_____
Name:	_____	Cell:	_____
Name:	_____	Cell:	_____

PAYER MIX:

Commercial Payers:	_____ %	Medicare:	_____ %	Cash:	_____ %

ADMINISTRATIVE:

Practice Manager:	_____	Cell:	_____	Email:	_____
Practice Owner:	_____	Cell:	_____	Email:	_____
Regenr8 Program Mgr:	_____	Cell:	_____	Email:	_____

_____
Signature