



Distant Care Program

Please complete the form below. All fields are required. Fax your completed form to (650) 566-9825, or mail it to 350 Cambridge Ave., Suite 250, Palo Alto, CA 94306 USA. Call (650) 566-9810 with any questions.

Demographic Information

First Name _____
Last Name: _____
E-Mail Address: _____
Phone: () _____
Address: _____
City: _____
State: _____ Zip Code: _____
Country: _____
Age: _____ Gender: Female Male

Diabetes Type: Type 1 Type 2 Gestational Not Sure
Membership Type: Monthly (\$130.00 USD)
How did you hear about us? _____

Payment Information

Payment Method (credit card only) Visa MasterCard Discover
Card Number (no spaces or dashes) _____
Name as it appears on your card: _____
Billing Zip Code: _____ Expiration Date: _____ Mo. _____ Yr. _____

I am currently a patient at Endocrine Metabolic Medical Center

I understand and agree to the following:

1. Endocrine Metabolic Medical Center does not provide emergency services. I will call 911 (or other emergency services) for appropriate help should I be in an emergency situation.
2. E-Mail is not a secure method of communication. I understand that there is a chance that e-mail communication could be intercepted, misdirected or otherwise tampered with by outside parties. I understand the risk of such violations to be extremely low.

Signed: _____
Name of Patient _____ Date _____