



## Online Diabetes and Metabolic Management 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: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender:  Female  Male

Diabetes Type:  Type 1  Type 2  Gestational  Not Sure  
How did you hear about us? \_\_\_\_\_

### Payment Information

Choice of Plan:  \$200 Monthly  \$2,200 Annually  
Payment Method (credit card only)  Visa  MasterCard  Discover  AMEX  
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 \_\_\_\_\_