1health Portal Enrollment Form

Practice Information

Full Legal Name:

Primary Address:

City: State: Zip:

Telephone: Fax:

Practice Type: ◯ Solo ◯ Speciality Group ◯ Conciege Model **Phlebotomy:** ◯ In-house ◯ Send-out (Quest/LabCorp)

Group NPI#: EHR System:

Provider Information

Provider's First Name: Last Name:

Provider's Email Address: Physician's NPI:

Provider's Specialty: State:

Provider Credentials: ◯ MD ◯ PA/NP ◯ DO **Board Certified?** ◯ Yes ◯ No

Nurse/Medical Assistant Contact Information

First Name: Last Name:

Email Address: Phone Number:

Fax:

Completed By: Phone/Email: Date: ____ | ____ | ____

For more information: Phone us at (424) 758-0100 or visit us at www.dxterity.com or email us at info@dxterity.com
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