ZÜPMED

APPLICATION FOR MEMBERSHIP AND SPECIALTY PROGRAMS

Welcome! Thank you for your interest in ZüpMed and the trust you've placed in us. Please take a few moments to tell us a little about yourself. Kindly print all the information.

Personal Information

First: _____ Middle: _____ Last: _____

How would you like to be addressed? ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Date of Birth: _____

Are you interested in: ☐ Membership ☐ Weight Loss ☐ Women's Health ☐ Other

If Other, please provide additional information: _____

Are you applying for someone else? ☐ Another Individual ☐ Couple/Shared ☐ Family

Please list the names, birth dates, and relationships of the other individuals to you.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Your Contact Information

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email: _____ FAX: _____

Only secure portals should be used to exchange Personal Health Information. How do you prefer to be contacted:

☐ Text Message ☐ Email ☐ Phone

Physician Information

Do you have a Primary Care Physician (PCP)? ☐ Yes ☐ No ☐ Not Sure

If you answered yes, Name of PCP: _____

Do you intend to continue your relationship with your PCP? ☐ Yes ☐ No ☐ Not Sure

If you are a woman, do you regularly utilize the services of a GYN? ☐ Yes ☐ No

Please list the names of any Specialists or Subspecialists who help manage any of your medical problems:

Specialist/Subspecialist Name: _____

Specialist/Subspecialist Name: _____

Specialist/Subspecialist Name: _____

Important Information about Insurance

Medicare: Medicare patients are eligible to join ZüpMed but *may not submit* any ZüpMed charges to Medicare.

Do you have Medicare? ☐ Yes ☐ No

Commercial Health Insurance: ZüpMed does not participate in any health insurance plans, but we may try to assist you in getting covered or reimbursed for certain outside services.

Do you have Commercial Insurance? ☐ Yes ☐ No

Health Savings Accounts: You may be able to use a Section 125 plan such as an HSA or FSA to offset your Membership fees.

Do you plan to use an HSA or FSA? ☐ Yes ☐ No

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General Information
What is the primary reason for your interest in joining a ZüpMed Membership or Specialty program? ☐ More Time with Provider ☐ Easier Access to Care ☐ Continuity & Relationship-Based Care ☐ Personalized, Preventative Care How can we help you achieve your health goals? _____ _____ _____ Is there anything about you that you would like us to know? _____ _____ _____ How did you hear about us? _____

Prospective Member Signature: _____	**Date:** _____
Please email your completed application to LSmith@zupmed.com or deliver it to our Front Desk at your convenience. Thank you.	
Internal Office Use Only	
Reviewed By: _____	**Date:** _____