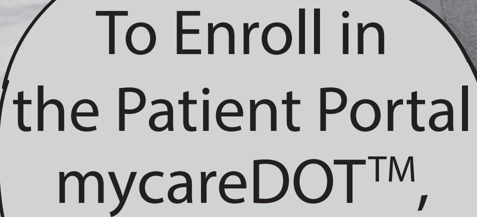
COMMUNITY CARE PHYSICIANS, P.C.



Name (of patient): ______________________ Date of Birth (of patient): __________

If you are enrolling your child or another person for whom you care:

Parent/Guardian/Caretaker Name: ______________________

Relationship to Patient: ______________________

Phone Number: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Email Address: ______________________

Signature: ______________________

Please read the terms and conditions in this brochure pertaining to the mycareDOT™ patient portal and email communications. By completing this form and submitting it to the front desk of your doctor's office, you are agreeing to the terms and allowing the office to invite you to join the patient portal via email invitation.

You may also receive health and company news and announcements from Community Care Physicians, PC through your portal account. If you do not understand or do not agree to comply with or do not consent to these policies or procedures, please do not complete this form to enroll in the patient portal.

A copy of this form will be scanned into your permanent medical record.

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