Dominion Primary Care

WHAT PRIMARY CARE SHOULD BE

Corporate Enrollment Form

Company Name:_____

Company Contact/Title:_____

Additional Contact/Title (Person to receive invoice):_____

Address: _____

City: _____ State: _____ Zip Code:

Phone Number:_____

Email:_____

Coverage (employer responsibility to Atlas MD)

Membership: _____%

Labs: _____%

Misc Charges _____%

Preferred Payment Method:

- ○ Monthly Check
- ○ Monthly Credit Card Auto-Debit Enabled: 1st
  (You may call to provide this billing information over the phone for security purposes)

23535 W IH10 Suite 2205
San Antonio, TX 78257

Tel 210-245-5580
Fax 210-245-9996

Dominion Primary Care

WHAT PRIMARY CARE SHOULD BE

Employees to be enrolled

	Name	**DOB**
1.		
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