DrFirst™ Practice Information Form

Practice Name:		Client ID:
Main Contact First Name:	Main Contact Last Name:	
Main Contact Phone Number:	Practice Email (must be different than provider email):	

Primary Location (This is how the practice information will appear on prescriptions):

Office Name (if different from practice name):		
Address Line 1:		
Address Line 2:		
City:	State:	Zip Code:
Phone Number:	Phone Number 2:	Fax:

Additional Location*:

Office Name:		
Address Line 1:		
Address Line 2:		
City:	State:	Zip Code:
Phone Number:	Phone Number 2:	Fax:

*If your practice has more than two locations, please fill out a DrFirst™ Additional Location Form.

Agreement

I, _____, attest that I am authorized to sign on behalf of the above-named practice and agree to hold Genius Solutions harmless for any complications resulting from the use of the DrFirst™ system and/or any of its associated programs and/or functions.

Additionally, I agree to have Genius Solutions transfer my e-prescribing service to DrFirst™, if necessary.

Signature: _____ Date: _____

Upon completion, please email paperwork to ehrsupport@geniussolutions.com.