DrFirst™ Provider Registration Form

Practice Name:	Client ID:

Provider Info (All fields are required. Incomplete forms will not be processed.):			
First Name:	Middle Initial:	Last Name:	Credentials (e.g. MD, DO):
Unique Provider Email Address (cannot be practice email):			
Practice Administrator*: ☐ Yes ☐ No		Electronic Prescriptions for Controlled Substances: ☐ Yes ☐ No	
Individual NPI:		DEA License #:	
Primary Medical State License # and State:			

*This person has the ability to reset login passwords and disable DrFirst™ access within the practice.

Note: If 'Yes' is selected for Electronic Prescriptions for Controlled Substances, additional activation and verification will be required.

A COPY OF YOUR DEA LICENSE IS REQUIRED.

Provider Signature: _____ Date: _____

By signing the above, I hereby authorize Genius Solutions to set up my electronic prescribing account through DrFirst™.

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