



Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Other Office Locations: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_  
 Website/Email Address: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_

**Practice Specialty (ties):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acupuncture             | <input type="checkbox"/> Infectious Disease Medicine | <input type="checkbox"/> Physical Medicine and Rehabilitation    |
| <input type="checkbox"/> Allergy & Immunology    | <input type="checkbox"/> Internal Medicine           | <input type="checkbox"/> Plastic Surgeon                         |
| <input type="checkbox"/> Anesthesiology          | <input type="checkbox"/> Maternal & Fetal Medicine   | <input type="checkbox"/> Podiatry                                |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Mental Health               | <input type="checkbox"/> Psychiatry for Children and Adolescents |
| <input type="checkbox"/> Cardiology              | <input type="checkbox"/> Neurology                   | <input type="checkbox"/> Psychiatry                              |
| <input type="checkbox"/> Cardiovascular Disease  | <input type="checkbox"/> Neurophysiology             | <input type="checkbox"/> Psychotherapy                           |
| <input type="checkbox"/> Chiropractic            | <input type="checkbox"/> Nuclear Medicine            | <input type="checkbox"/> Pulmonary Medicine                      |
| <input type="checkbox"/> Cosmetic Dentistry      | <input type="checkbox"/> Nutrition Services          | <input type="checkbox"/> Radiology                               |
| <input type="checkbox"/> Critical Care Medicine  | <input type="checkbox"/> Obstetrics & Gynecology     | <input type="checkbox"/> Speech Disabilities                     |
| <input type="checkbox"/> Dentist                 | <input type="checkbox"/> Oncologist                  | <input type="checkbox"/> Sports Medicine                         |
| <input type="checkbox"/> Dermatology             | <input type="checkbox"/> Oral Surgery                | <input type="checkbox"/> Surgery                                 |
| <input type="checkbox"/> Emergency Medicine      | <input type="checkbox"/> Orthopedic Surgery          | <input type="checkbox"/> Therapy - Physical                      |
| <input type="checkbox"/> Endocrinology           | Other _____  | <input type="checkbox"/> Urologist                               |
| <input type="checkbox"/> ENT - Ear, Nose, Throat | _____  | <input type="checkbox"/> Vascular & General Surgery              |
| <input type="checkbox"/> Family Practice         | <input type="checkbox"/> Pathology                   |  |
| <input type="checkbox"/> Gastroenterology        | <input type="checkbox"/> Pediatrics                  |  |
| <input type="checkbox"/> General Practice        | <input type="checkbox"/> Pediatric Dentistry         |  |

**REQUIRED**

<b>Office Information</b>		<b>Insurance &amp; Rates</b>		
<b>Office Hours:</b>	Weekdays: _____ Weekends: _____	<b>Provider Network Affiliations:</b>		
<b>Peak Hours:</b>	_____	<b>HMO (Referral Required) or PPO:</b>	Yes	No
<b>General Address:</b>	_____	<b>HMO Direct Access Program:</b>	Yes	No
<b>Practice Association(s):</b>	_____	<b>Medicare:</b>	Yes	No
<b>Parking Type:</b>	_____	<b>Workmen's Comp:</b>	Yes	No
<b>Primary Language:</b>	_____	<b>Accept Uninsured Patients:</b>	Yes	No
<b>Additional Languages:</b>	_____	<b>Emergency Care:</b>	Yes	No
<b>Doctor Website :</b>	_____	<b>Primary Hospital:</b>	_____	

**OPTIONAL**

<b>Education &amp; Training</b>		<b>Organizations &amp; Awards</b>	
<b>Residency Training:</b>	_____	<b>Board Certified:</b>	_____
<b>Medical School:</b>	_____	<b>Certification:</b>	_____
<b>Graduation Year:</b>	_____	<b>Member Organizations:</b>	_____
<b>University/College:</b>	_____		
<b>College Degree:</b>	_____		
<b>College Grad Year:</b>	_____		
<b>Primary Specialty:</b>	_____		
		<b>Personal Information</b>	
		<b>Doctor Name:</b>	_____
		<b>Gender:</b>	Male _____ Female _____
		<b>Age:</b>	25 - 35 _____ 51 - 60 _____ 36 - 50 _____ 60+ _____

**Initials:** \_\_\_\_\_





Please read all sections thoroughly. Thank you!

Yes, I would like to list my practice information on hobokendoctors web site. Please bill me:

\$60 introductory rate for the remainder of 2008\_\_\_\_\_

Are you interested in sponsoring your main specialty page for an all inclusive monthly fee of \$100?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

This would allow you to include a detail bio of yourself and practice, photos and other information not listed in our general section.

Hobokendoctors.com is a community based site. As such, are there any other features or information we could provide which you think may be beneficial to the residents of Hoboken? If so, please describe. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate which, if any, of the following services provided by Priority Support and our affiliates, you may be interested in?

- IT services       offsite data backup    Business Telephone Systems
- Website Design     Payroll Services       Receptionist Services
- HR Consulting/Bookkeeping Services

I hereby certify that the information set forth on this form is true and accurate and that I am either the person named above or an authorized representative of the person named above. I hereby authorize Priority Support, Inc. and any of it's Websites to use my information provided herein as it sees fit, whether for the public good or for profitable ventures, and acknowledge that the information set forth herein is neither private nor proprietary to me, and is generally available in the public domain. If at any time this information changes or becomes outdated I will contact Priority Support at 212-787-7678 in a timely manner. I also understand that Priority Support may remove my information from any of it's Websites for any reason at any time.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

