



Registration Form

Physician Name: _____

State License #: _____ **DEA License #:** _____

National Provider Identifier (NPI): _____

Practice Name: _____

Number of Physicians: _____

Name of Practice Management System: _____

Office Point of Contact (POC): _____

POC E-Mail Address: _____

Primary Address: _____

Primary Phone: _____

Primary Fax: _____

Average number of Prescriptions written per week: _____

Plan on using a PDA if so which one? _____

How did you hear about RxNT? _____

Physician Signature Box: _____ **Date:** _____