Family Medicine West of Wartburg

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Please fill out the Name, Date of Birth, and the Date.
If you would like to opt-in to our Patient Portal System, Check Yes or No below.
If you check **Yes**, please (clearly) write your e-mail address below.

Name (Print Please):_____

Date of Birth:_____

Date:_____

☐ **Yes** ☐ **No**

Email: _____