

NEWPORT BEACH MEDICAL ASSOCIATES, INC.

Please return in the enclosed envelope.

1st Patient's Full Name _____

Date of Birth ____/____/____

2nd Patient's Full Name _____

Date of Birth ____/____/____

1st Child (age 17-25) _____

Date of Birth ____/____/____

2nd Child (age 17-25) _____

Date of Birth ____/____/____

Address _____

City _____

State _____ Zip Code _____

Telephone (____) _____

Cellular (____) _____

E-mail _____

Individual

\$2,000 per year

Two Adults

\$4,000 per year

Family (two adults & children 17-25)

\$4,500 per year

Yes, I would like to enroll in Dr. Brouwer's concierge practice.

Enclosed is my annual check to:

Newport Beach Medical Associates

(Please date the check **after** Jan. 1 if your enrollment date is Jan. or Feb.)

Please charge my annual or semi-annual fee to:

VISA MASTERCARD

Card Number _____

Expiration Date ____/____

Name on Card _____

Signature _____ Date _____

DAVID W. BROUWER, M.D., F.A.C.P.

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