

Stratford Software, Inc.

Practice registration change of address

ACCOUNT # _____

1. Full Name and address of Practice for license. Appears on statements, insurance forms and reports. (Max 25 characters/line) Note: the new HCFA form only allows 3 lines for the name and address). **PLEASE PRINT.** We must charge for changes if not clearly printed; see below.

Name _____

Street Address _____

City State Zip _____

Phone Number _____

2. State License Number	3. Tax I.D.	4. Social Security Number
5. Medicaid (Medi-Cal) I.D.	6. Medicare ID (PIN)	7. Medicare UPIN

8. Specialty _____

9. Do you want to track the productivity of individual physicians? **YES NO**

10. Do you want to post transactions **OPEN ITEM** or **BALANCE FORWARD**? (Circle one)
(You may post open item on selected account types and balance forward on others)

11. How would you like to receive your software? **CD DOWNLOAD** (Circle one)

12. Do you have a least 40MB of free space on your hard drive? **YES NO**

13. What version of WINDOWS is on your computer? _____

14. Forms to be ordered: **statements insurance report paper envelopes** other _____

15. Name of contact person and office hours (days, hours) _____

I verify that the information in question #1 is accurate and I must pay \$35.00 for changes to item #1.

Signature: _____

Print Name: _____ Date: _____

Credit Card Number: _____ Expiration Date: _____

We need the information above to process your order for a non-limited account. Please include full payment with your order. We prefer MasterCard or Visa. Allow 1 week to fill your order.

WE GIVE PRIORITY to paypal and faxed credit card orders

Fax 206.984.3846