



Your information is for membership purposes only and will not be shared.

Last Name _____ First Name _____ MI _____

Last 4 Digits of Your SSN _____ DOB _____ Sex M F

Address _____

City _____ State _____ Zip _____

E-mail _____

Home Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____

Home phone _____ Cell phone _____

1) How did you hear about Silver Elite? (please check all that apply)

- Received something in the mail
- Web site _____ (What Web site?)
- Newspaper or Magazine ad _____ (Which publication?)
- Referred by someone: _____ (His or her name?)
- Other _____

2) Primary Care Physician? _____

3) What physician group is your primary care physician affiliated with? (please check one)

- Family Medical Group
- Indian Health Care
- OMNI Medical Group
- SouthCrest
- Utica Park Clinic
- VA
- Warren Clinic
- Other _____

4) Primary Insurance? _____ 5) Secondary Insurance? _____

6) Favorite Hobby? _____

7) T-Shirt Size? ___ S ___ M ___ L ___ XL ___ 2X ___ 3X (please check one)

Return Your Silver Elite Membership Application

By Mail

Tina Williams
Bailey Medical Center
10502 N. 110th E. Ave.
Owasso, OK 74055

By Fax

918.376.8474

By E-mail

tina.williams@baileymedicalcenter.com

Thank you for applying! If you do not receive anything from us within 30 days, please call
918.376.8522.