



## PRE-REGISTRATION FORM

Please complete the information below and return this form to the **Good Health Gateway®** table at the upcoming event. **All fields are required to register you for the program.**

### PERSONAL INFORMATION

First name: \_\_\_\_\_

Last name: \_\_\_\_\_

Date of Birth: (MM/DD/YYYY) \_\_\_\_\_

Mailing Address 1: (Street) \_\_\_\_\_

Address 2: (Apt, Floor, PO Box) \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

For Text Message Program Reminders

Email: \_\_\_\_\_

### Authorization for Abacus Health Solutions, LLC

Administrators of the **Good Health Gateway** Programs

#### IMPORTANT

The member named above should be the person who signs this document authorizing Abacus Health Solutions, LLC. and its affiliates to register the member on the **Good Health Gateway** web portal (<https://www.GoodHealthGateway.com>) on his or her behalf. If the member is a minor, a parent of a legal guardian must sign; if the member is unable to sign for any other reason, a legal representative must sign and attach proof of authority to do so. Following registration, we will provide you with your login information to the **Good Health Gateway** web portal. For your privacy, it is recommended that you change your username and password.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Relationship to Member (*if not member*): \_\_\_\_\_ Date: \_\_\_\_\_