

LIST ANY NON-PRESCRIPTION MEDICATIONS YOU WOULD LIKE TO RECEIVE:
 (Aspirin, Vitamins, etc.)

MEDICATION & DOSAGE	MORNING	NOON	EVENING	BEDTIME
Please list the actual times you take medications below				

LIST ALL INSURANCES THAT PAY FOR YOUR PRESCRIPTIONS:

(If possible, please include a photocopy of all insurance cards)

INS. NAME: _____ ID#: _____ GROUP#: _____ BIN#: _____

INS. NAME: _____ ID#: _____ GROUP#: _____ BIN#: _____

INS. NAME: _____ ID#: _____ GROUP#: _____ BIN#: _____

HDAP/ADAP: Have you ever applied for HDAP/ADAP? Yes Account #: _____ No

BILLING ADDRESS (IF DIFFERENT FROM ABOVE): Any money owed, co-pays, etc will be billed monthly.

BILL HOLDER'S NAME: _____ TEL#: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

YOU MAY PAY WITH A CREDIT CARD:

CARD HOLDER'S NAME: _____ TYPE OF CARD: _____ VIN#: _____

CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

DELIVERY INSTRUCTIONS – HOW WOULD YOU LIKE TO RECEIVE YOUR MEDICATIONS?:

Standard Delivery (From PharmaHealth Driver) FedEx Delivery Other

Please list any special instructions regarding your delivery. For example: I attend daycare (please list days and times), Please use a specific door, Please call before delivering, etc.

REFERRAL SOURCE?: _____

(Please list name of person, organization or media source)

PRINTED NAME: _____

SIGNATURE: _____

Please Return This Form To: 360 Faunce Corner Rd. Dartmouth, MA 02747 or Fax both pages to: (508) 998-8036. You may also leave this application with the pharmacist at any PharmaHealth Pharmacy location.