FAX OR ESCRIPT ALL PRESCRIPTIONS TO

PRXP OF CA

4345 E Lowell Street, Suites C & D | Ontario, CA 91761

Telephone & Fax: 888-505-1485

Clinic Name: 340B Eligible: ☐ Yes ☐ No

Today's Date: PCP: _____

PATIENT INFORMATION (REQUIRED INFORMATION)

Patient's Last Name: **First:** **Middle:**	Sex: (Check One) ❑ Male ❑ Female	Birth Date: / /
Street Address:	Gender Identity: ☐ Male ☐ Female ☐ Transgender Other:	Home Telephone Number: ( )
P.O. Box:	City, State, Zip:	Emergency Contact:	Emergency Contact Phone Number

CURRENT PHARMACY INFORMATION

Pharmacy Name	Telephone Number ( )	Fax Number ( )
Street Address	City, State	ZIP Code

INSURANCE INFORMATION
(ATTACH FRONT AND BACK OF INSURANCE CARD)

Policy Insurance	PCN	BIN
Subscriber's Name	Group Number	Patient ID

Patient Relationship to Subscriber (Check One)	❑ Self	❑ Spouse	❑ Child	❑ Other

DELIVERY INFORMATION
(CHECK ONE)

☐ Patient's Address:	☐ Prescriber's Address	☐ Other	Street Address City, State, Zip (Print Clearly)

ACKNOWLEDGEMENT FORM
(PLEASE SIGN)

BY SIGNING BELOW, I AUTHORIZE PRXP OF CA PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRATICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.

_____ _____

Patient/Guardian Signature *Date*

**Licensed in CA*