

FAX OR ESCRIPT ALL PRESCRIPTIONS TO
PHYSICIANS RX PHARMACY of Clinton Inc.
 9131 Piscataway Road, Suite 670 | Clinton, Maryland 20735
Telephone: (800)-672-1088 Fax:(800)-621-1181

Clinic Name: _____ 340B Eligible: Yes No

Today's Date: _____ PCP: _____

PATIENT INFORMATION (REQUIRED INFORMATION)					
Patient's Last Name: First: Middle:			Sex: (Check One) <input type="checkbox"/> Male <input type="checkbox"/> 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)		<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other	
DELIVERY INFORMATION (CHECK ONE)					
Patient's Address:		Prescriber's Address		Other Street Address City, State, Zip (Print Clearly)	
ACKNOWLEDGEMENT FORM (PLEASE SIGN)					
<i>BY SIGNING BELOW, I AUTHORIZE PHYSICIANS RX PHARMACY OF CLINTON TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.</i>					
<i>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.</i>					
_____			_____		
<i>Patient/Guardian Signature</i>			<i>Date</i>		