FAX OR ESCRIPT ALL PRESCRIPTIONS TO

Broadway Family Pharmacy

510 Amsterdam Ave, STR1 (South Store)|New York, NY 10024-3935

Telephone: 212-724-1950 Fax: 212-724-1946

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:	Emergecy 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 (Print Clearly)	Street Address City, State, ZIP

ACKNOWLEDGEMENT FORM
(PLEASE SIGN)

BY SIGNING BELOW, I AUTHORIZE BROADWAY FAMILY 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 NY, CT and NJ*