Allcare Specialty Pharmacy

Phone: 501-217-8880 / Toll Free: 855-780-5500
Fax: 501-217-8885 / Toll Free: 855-780-5505

PATIENT ENROLLMENT FORM

PATIENT INFORMATION

Last Name	First Name	Date of Birth:	Gender: ☐M ☐F
Street Address			
City	State	Zip Code	
Daytime Phone:	Cell Phone:	Email Address	

INSURANCE INFORMATION

Primary Ins: Policy Name:		Rx Bin	Rx PCN
Cardholder ID#:	Cardholder Name:	Rx Grp	Person Code:
Secondary Ins: Policy Name:		Rx Bin	Rx PCN
Cardholder ID#:	Cardholder Name:	Rx Grp	Person Code:

PATIENT HISTORY

Medication Allergies

❑No Known Allergies	❑Aspirin	❑Erythromycin	❑Penicillin
❑Sulfa	❑Codeine	❑Iodine	❑Other:

Health Conditions

❑Arthritis	❑Glaucoma	❑High Cholesterol	❑Depression
❑Asthma	❑Epilepsy	❑Heart Condition	❑Thyroid
❑Diabetes	❑High Blood Pressure	❑Thyroid	❑Ulcer
❑Reflux	❑Other:		

List Current Medications (including over the counter medications, vitamin and herbal supplements)

PAYMENT OPTIONS

Payment Method: ☐Credit Card ☐Check ☐Money Order *Payment is due with each order. Do not send cash.		
Credit Card Information	Name on Card	
Billing Address		
City	State	Zip Code
Card Number	Exp Date	Security Code
☐Please place credit card on file for future orders		
Cardholder Signature:		Date:

PRESCRIPTION INFORMATION

☐Fill enclosed Prescription ☐Put this prescription on file to be filled later ☐ Call my doctor and request a prescription	
Medication(s) being requested:	
Doctor's Name:	Doctor's Phone Number:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to Allcare Specialty Pharmacy.

Signature:_____ Date:_____

To refuse generics check here (☐), AND sign and date.

Allcare Specialty Pharmacy substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products. " I understand that I have the right to refuse generic medications. I understand this may result in a higher cost to me, that I am responsible for payment, and that drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept these conditions."

Signature:_____ Date:_____