BOUVIER
Pharmacy & Home Medical Solutions

New Patient Enrollment Form

Preferred Start Date

Personal Information			
Last Name	First Name	MI	Suffix
Street Address	City	State	Zip
Daytime Telephone	Social Security Number	Date of Birth	Sex: Male / Female

Primary Care Physician			
Last Name	First Name	Telephone	
Street Address	City	State	Zip

Other Physician			
Last Name	First Name	Telephone	
Street Address	City	State	Zip

Allergies to Medications

Medication List (Please provide written prescriptions if available, or request MD to send to pharmacy)

MEDICATION	DOSE	DIRECTIONS	TIMES OF DOSES

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FACILITY NAME (If patient is under nursing care)

Primary Contact			
Name	Phone	Relation	
Address	City	State	Zip
Email	What is the easiest way to contact you?		
Use this as billing address? Y/N	Auto Pay with credit card? Please give card number & expiration date here		

Emergency Contact Information		
Name	Phone	Relation

Previous Pharmacy (If known)	
Name	Phone

Prescription Drug Coverage		
Insurer Name	Relationship to Policy Holder	
Identification number	Person code/Suffix (if applicable)	
Rx group number (if listed)	RxBIN (if listed)	RxPCN (if listed)

If possible, please attach a copy of the prescription insurance card or cards. If there is more than one coverage type, please attach additional information on a separate sheet of paper.

Medicare Information
ID Number

Waiver of tamper proof packaging

I fully understand that this is not a child proof system and I accept full responsibility for keeping these medications in a safe place away from children or other people not intended to take them.

_______________________________ *Signature of patient or patient's personal representative*

___________ *Date*