Employee Pharmacy
Patient Information

Employee Name_____

Date of Birth_____

Address_____

Home Phone #_____ **Work Phone #**_____

Allergies_____

Insurance: Aetna_____ **Blue Cross**_____ **Other**_____

Policy Number: _____

Covered Family Members:

Name	Relationship to Cardholder	Date of Birth	Allergies?	Uses Other Insurance?

Please bring any additional insurance cards you or your family members use for prescriptions.

Would you like to be contacted if there is a problem with your prescription(s)? If yes, phone number to call:_____

*****If you would like to be contacted via email for problems or refills, please ask to sign a HIPAA authorization.*****

Email Address: _____

****WHEN COMPLETE, you may either bring this form to the secure drop box located outside the new pharmacy, or fax it to 276-2600 ****