University of Rochester Specialty Pharmacy
Patient Information Sheet

Please fill out information sheet in blue or black ink and return to the specialty pharmacy via the secure drop box outside the employee pharmacy, email, U.S. mail or fax.

Patient Full Name:	Sex:	Date of Birth: / /	Date: / /
Home Address:			
City:	State:	Zip Code:	Home Phone: - -
Work Address:			
Work Phone: - -	Cell Phone: - -		Pager: - -
E-mail: @			Insurance: ☐ Blue Cross ☐ Other _____
Policy Number:	Group Number:	Name of Subscriber:	Relationship to Subscriber:
Allergies: ☐ Latex ☐ None			

MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY TAKEN	WHAT THIS IS TAKEN FOR

If there is a problem with your prescription how would you like to be contacted?

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Pager ☐ E-mail ☐ Other _____

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