

Patient Enrollment



DATE	NEEDS BY DATE	SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE - FIRST DOSE <input type="checkbox"/> OFFICE - ALL DOSES <input type="checkbox"/> OTHER:
REFERRED BY		TEL

PATIENT INFORMATION		ALL INFORMATION IS CONFIDENTIAL AND USED FOR CLINICAL PURPOSES ONLY	
Patient Name		Preferred Name	
Main Phone	Alternative Phone	Date of Birth	Social Security #
Patient Address			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> MtF Female <input type="checkbox"/> FtM Male <input type="checkbox"/> other:			
Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> other:			Pronouns
Allergies		340B Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HIV <input type="checkbox"/> PrEP <input type="checkbox"/> Other

PRESCRIBER INFORMATION	
Prescriber Name	
Address	City, State, Zip
Office Contact	Phone

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

INSURANCE	
<input type="checkbox"/> Private Insurance ID#:	<input type="checkbox"/> Medicaid ID#:
<input type="checkbox"/> Medicare Part D ID#:	<input type="checkbox"/> Other: ID#:

PRESCRIPTION TRANSFER	
Current Pharmacy Name	Phone Number
Prescription(s)	