Patient Enrollment

Prescription(s)



DATE	NEEDS	SHIP TO:									
-7	BY DATE		T 🖵 OFFICE - FIRST D	FFICE - ALL	DOSES OTHER:						
REFERRED BY				TEL							
PATIENT INFORM	ATION	ALL INFO	DRMATION IS CO	NFIDEN	TIAL AND	USED FOR CLI	NICAL P	URPOSES ONLY			
Patient Name			Preferred Name								
						12					
Main Phone	Alternative Phone	Alternative Phone		Date of Birth			Social Security #				
Patient Address											
Sex											
	Intersex Intersex Intersex Intersex Intersex Intersex Intersex Intersection	I Male □ other:									
Gender Identity				Pronouns							
☐ Male ☐ Female ☐ Tr											
Allergies	340B Eligible	☐ Yes	□No	□HIV	□ PrEP	☐ Other					
						'					
PRESCRIBER INFO	PRMATION										
Prescriber Name											
Address	City, State, Zip										
Office Contact	Phone										
	PLEASE FAX BOTH	H SIDES OF PRES	CRIPTION CA	RD AN	ND MED	ICAL CARD					
INSURANCE											
☐ Private Insurance	☐ Medicaid ID#:										
	ID#:										
☐ Medicare Part D	☐ Other:			ID#:							
PRESCRIPTION TO	DANCEED										
	KANSFER										
Current Pharmacy Name					Pho	ne nber					

Patient Enrollment

PATIENT INFORM	/ATI	ОИ												
Patient Name							Date of Birth							
Patient Address														
PRESCRIBER INF	ORM	IATION												
Prescriber Name						Entity/Organization								
Address						City, State, Zip								
Prescriber Type ☐ Physician (MD or DO) ☐ Nurse Practitioner ☐ Physician's Assistant						Supervising Physician (If prescriber is a NP or PA):								
Office Contact Tel						Fax								
DEA#						NPI #								
PRESCRIPTION	NEO													
PRESCRIPTION I	NFO	RMATION	V											
☐ Written Below	en Below				☐ Compliance Packaging ☐ Spanish Instructions									
MEDICATION		DOSE	/STRENGTH				DIRECTIO	ONS			QUANTITY	REFILLS		
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