

Patient Enrollment



DATE	NEEDS BY DATE	SHIP TO: ☐ PATIENT ☐ OFFICE - FIRST DOSE ☐ OFFICE - ALL DOSES ☐ 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 ☐ Male ☐ Female ☐ Intersex ☐ MtF Female ☐ FtM Male ☐ other:			
Gender Identity ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ other:			Pronouns
Allergies		340B Eligible ☐ Yes ☐ No	☐ HIV ☐ PrEP ☐ Other

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

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

INSURANCE	
☐ Private Insurance ID#:	☐ Medicaid ID#:
☐ Medicare Part D ID#:	☐ Other: ID#:

PRESCRIPTION TRANSFER	
Current Pharmacy Name	Phone Number
Prescription(s)	