Pharmacy Intake Form

CHESTERFIELD PHARMACY

703 Columbia St.
Seattle, WA 98104
Tel: (206) 838-6070
Fax: (206) 838-9775

INFORMATION THAT THE PHARMACY WILL NEED UPON ADMITTING NEW PATIENTS:

PATIENT NAME _____

ADDRESS _____

PHONE _____

BIRTHDAY _____

SS#/MEDICARE # _____

DOCTOR NAME _____

ADDRESS _____

PHONE _____

FAX _____

ALLERGY _____

INSURANCE INFORMATION:
DSHS WASHINGTON MEDICAID ID# (PIC) _____

MEDICARE PART D NAME OF PLAN & PHONE #

<<ID, BIN, RX GROUP, PCN>>

NAME OF CURRENT PHARMACY & PHONE # _____
IF POSIBLE PROVIDE OLD RX # _____

HOW SOON THE PATIENT NEEDS MEDICATION? WHEN IS THE LAST FILL DATE?

PATIENT REQUESTS CHANGE TO CHESTERFIELD PHARMACY

_____

PATIENT SIGNATURE **DATE**