





## New Client Enrollment Form - Page 2

**Client Name**

Name

**Emergency Contact Information**

Name

Phone

Relation

**Previous Pharmacy (If Known)**

Name

phone

**Prescription Drug Insurance Coverage**

Insurer Name:

Relationship to Policyholder:

Identification Number:

Person Code/Suffix (if applicable):

Rx Group Number:

RXBIN (if listed):

RXPCN (if listed):

**If possible, please attach a copy of the prescription insurance card or cards. If there is more than one coverage type, please attach additional information on a separate sheet of paper.**

**Medicare information**

ID Number

**Waiver of tamper proof packaging**

I fully understand that this is not a child proof system and I accept full responsibility for keeping these medications in a safe place away from children or other people not intended to take them.

\_\_\_\_\_  
*Signature of Patient or Patient's Personal Representative*\_\_\_\_\_  
*Date*