Collier DRUG STORES

Multi-Dose Packaging Patient Form

Patient Information

Name: _____ Today's Date: / /

Address: _____ Phone (H): _____

City: _____ State: _____ Zip: _____ Phone (C): _____

Date of Birth: / / Age: _____ Sex: M____ F____

Drug Allergies: _____

Other Allergies/Intolerances: _____

Primary Care Physician: _____ Phone: _____

Insurance Information

Primary Insurance Provider: _____

Name of Cardholder: _____

ID#: _____ BIN: _____

RxGroup#: _____ PCN: _____

Relationship of patient to cardholder: _____

Secondary Insurance Provider: _____

Name of Cardholder: _____

ID#: _____ BIN: _____

RxGroup#: _____ PCN: _____

Relationship of patient to cardholder: _____

Caregiver/Emergency Contact Information

1. Name: _____ Relationship to Patient: _____

   Phone: _____ Email: _____

2. Name: _____ Relationship to Patient: _____

   Phone: _____ Email: _____

Packaging & Payment Preferences

How would you like to receive your monthly packs? Pick-up _____ Delivery _____

Delivery Address: _____

City: _____ State: _____ Zip: _____

Special Notes: _____

Preferred Payment Method: Cash/Check _____ Credit Card _____ Store Account _____

Credit Card Info

Name on Card: _____

CC#: _____

Exp. Date: _____ /_____

Store Account Info

Name on Acct: _____

Billing Address: _____

City, State, Zip: _____

Prescription and Over the Counter Medication List

	Drug	Dose	How you take this medication	Dosing Time	Prescriber
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					