

Employee/Retiree Information

Check One: Employee Retiree COBRA

PHARMACY ID. CARD NUMBER		EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER		
LAST NAME		FIRST NAME		MIDDLE INITIAL
SHIP TO THE ADDRESS BELOW. <input type="checkbox"/> Please check here if this is a change of address.				
STREET		APT. #	CITY	
STATE	ZIP CODE	DAYTIME PHONE ()		
I certify that information on this form is correct.				
X _____		Employee/Retiree Signature		Date _____

Patient No. 1 Information

LAST NAME		FIRST NAME			MIDDLE INITIAL
DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO EMPLOYEE/RETIREE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> COLLATERAL DEPENDENT		IS THIS YOUR FIRST MAIL ORDER PRESCRIPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DRUG ALLERGIES:		<input type="checkbox"/> NONE <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFONAMIDES <input type="checkbox"/> OTHER: _____			
PHYSICIAN INFORMATION					
LAST NAME		FIRST NAME		MIDDLE INITIAL	PHONE NUMBER ()

Patient No. 2 Information

LAST NAME		FIRST NAME			MIDDLE INITIAL
DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO EMPLOYEE/RETIREE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> COLLATERAL DEPENDENT		IS THIS YOUR FIRST MAIL ORDER PRESCRIPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DRUG ALLERGIES:		<input type="checkbox"/> NONE <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFONAMIDES <input type="checkbox"/> OTHER: _____			
PHYSICIAN INFORMATION					
LAST NAME		FIRST NAME		MIDDLE INITIAL	PHONE NUMBER ()

Patient No. 3 Information

LAST NAME		FIRST NAME			MIDDLE INITIAL
DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO EMPLOYEE/RETIREE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> COLLATERAL DEPENDENT		IS THIS YOUR FIRST MAIL ORDER PRESCRIPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DRUG ALLERGIES:		<input type="checkbox"/> NONE <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFONAMIDES <input type="checkbox"/> OTHER: _____			
PHYSICIAN INFORMATION					
LAST NAME		FIRST NAME		MIDDLE INITIAL	PHONE NUMBER ()