WhidbeyHealth
COMMUNITY PHARMACY

DELIVERY CUSTOMER ENROLLMENT FORM

PATIENT INFORMATION

Last Name:	First Name:	DOB: / /
Street Address:		☐ M ☐ F
City:	State:	ZIP:
Daytime Phone:	Cell Phone:	Email:

INSURANCE INFORMATION

Primary Policy Name:		Rx Bin	Rx PCN
Cardholder ID#:	Cardholder Name:	Rx Grp	Person Code
Secondary Policy Name:		Rx Bin	Rx PCN
Cardholder ID#:	Cardholder Name:	Rx Grp	Personal Code

PATIENT HISTORY

Medication Allergies ☐ No Known Medication Allergies

Current Health Conditions

List Current Medications (including over the counter medications, vitamins and herbal supplements)

PAYMENT INFORMATION

Credit Card, HSA/FSA or Debit Card

Name on Card:	Card Number:	
Billing Address:	Exp Date:	Security Code:
City:	State:	ZIP:
Cardholder Signature:		Date:

☐ Please place credit card on file for future orders.

Please read and sign to complete order.
I understand that payment is required prior to delivery. I authorize the pharmacy to charge the credit card provided for the copay cost of my medications. I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment, and prescription drug history to WhidbeyHealth Community Pharmacy.

Signature: _____ Date: _____