MALECON PHARMACY

In partnership with McKESSON
Empowering Healthcare

NEW PATIENT ENROLLMENT FORM

Fax: 800-557-0966 Tel: 800-797-3127 E-Prescribe: Malecon Pharmacy

PATIENT PROFILE

Last Name: ____________________ First Name: ____________________

Street: ____________________ City: ____________________

State: __________ Zip: __________ Phone: ____________________ Cell: ____________________

DOB: __________ MALE or FEMALE Social Security # ____________________ Date Needed: ____________________

Allergies: ____

Diagnosis /ICD9 Code: ____________________ Consent to verified Auto-refill Yes or No

Delivery to: Home or Office Office Hours of Operation: ____________________

Office Address: Company Name: ____________________ Street: ____________________

City: ____________________ State: __________ Zip: __________ Phone: ____________________

INSURANCE INFORMATION

Please fill out below or fax both sides of patient's insurance card(s).

Primary Insurance: ____________________

Insured: ____________________

Policy#: ____________________

Group#: ____________________

BIN #: __________ PCN# __________

Secondary Insurance: ____________________

Insured: ____________________

Policy#: ____________________

Group#: ____________________

BIN #: __________ PCN# __________

Current Pharmacy Name: ____________________ Phone Number: ____________________

PATIENTS SIGNATURE

Patient herewith certifies all the information above, acknowledges the receipt of Notice of Privacy Practices and requests to transfer his existing prescription from his current Pharmacy (if applicable)

Patient's Signature: ____ Date: ____________________

PHYSICIAN INFORMATION

Physician's Name: ____________________ **Office Contact:** ____________________

Phone: ____________________ **Fax:** ____________________ **E-mail:** ____________________

Address: ____

License#: __________ **NPI#:** __________ **DEA#:** __________ **UPIN#:** __________

PHYSICIAN'S SIGNATURE: ____ **DATE:** ____________________

This Form should be filled in for all new patients you are referring to us. For refills or new RX's of existing patients you may use this form or fax/e-send a copy of the prescription – whatever is more convenient for you.