PHARMACY HOME CARE OF EAST TENNESSEE

Medication Management Made Easy For Everyone

www.RxHomeCare.com 423.790.7336

PATIENT INFORMATION

(PLEASE COMPLETE ALL PATIENT INFORMATION)

NAME: _____ FACILITY: _____

ROOM NUMBER: _____ DATE OF MEDICATION TO START: _____/_____/_____

DATE OF BIRTH: _____/_____/_____ SEX: MALE / FEMALE

MEDICATION ALLERGIES: _____

PRIMARY PHYSICIAN: _____

SOCIAL SECURITY NUMBER: _____

MEDICARE ID # (RED, WHITE, BLUE CARD): _____

(PLEASE PROVIDE COPY OF ALL INSURANCE AND/OR MEDICARE CARDS)

RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATIONSHIP: _____

PHONE (CELL): _____ PHONE (WORK): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I, THE UNDERSIGNED, CERTIFY RESPONSIBILITY FOR PAYMENT OF THE PHARMACY ACCOUNTOF THE CUSTOMER NAMED ABOVE. IF THIS ACCOUNT SHOULD FALL INTO DEFAULT, I UNDERSTAND I WILL BE RESPONISBLE FOR ANY FEES INCURRED IN THE COLLECTION PROCESS.

SIGNATURE: _____ DATE: _____/_____/_____