Community Health Pharmacy

158 Brentwood Drive, Suite #6 • Colchester, Vermont • Fax: (877) 899-2622

PATIENT INFORMATION

◯ Check here if your patient information is already on file with Community Health Pharmacy.

Date of Last Office Visit: _____

Social Security Number: _____ (Optional)

Name: _____ Date of Birth: _____ Sex: ◯ Male ◯ Female

Billing Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____ Daytime Phone: _____

◯ Check here if shipping address is the same as billing address Evening Phone: _____

Shipping Address*: _____ Physician Name: _____

City: _____ State: _____ Zip: _____

Clinic:
- ◯ CHCB- Community Health Center of Burlington
- ◯ Lamoille Health Partners
- ◯ THC - The Health Center
- ◯ CVMC – Central Vermont Medical Center
- ◯ NOTCH - Northern Tier Center for Health
- ◯ NCHC - Northern Counties Healthcare
- ◯ MHC - Mountain Health Center

*Your prescription will be mailed to the shipping address on file.

◯ **If you would like autofill, please check here**

Medications being filled at other pharmacies: _____

OTC items currently taking: _____

DRUG ALLERGIES AND REACTIONS

	Severity: Mild	Moderate	Severe	Anaphylaxis
◯ None				
◯ Codeine	◯	◯	◯	◯
◯ Sulfa	◯	◯	◯	◯
◯ Aspirin	◯	◯	◯	◯
◯ Penicillin	◯	◯	◯	◯
◯ Other: _____	◯	◯	◯	◯

Explanations or Additional Info: _____

CHRONIC CONDITIONS/DISEASE STATES

INSURANCE AND BILLING INFORMATION

◯ I have no prescription drug coverage through my medical insurance.

◯ I have Medicare Part D.

◯ I have Medicaid ID: _____

◯ I have insurance. My prescription drug carrier is: _____ Rx BIN: _____ Rx PCN: _____

Cardholder ID: _____ Group ID: _____ Relationship to Cardholder: ◯ Self ◯ Spouse ◯ Child ◯ Other

PAYMENT INFORMATION

To process your shipping prescriptions quickly, please provide a payment method:

◯ I will pay by check ◯ I will pay by money order ◯ I will pay by credit card

Please complete credit card information below:

◯ Visa ◯ Mastercard ◯ Discover ◯ American Express

_____
Name of Responsible Party

Credit Card Number: _____ Expiration Date: _____ MM/YYYY

X _____
Signature of Card Holder

◯ Check here to decline keeping credit card number on file.