Cabrini Pharmacy Services

New Patient Form

Highlighted fields = Required Information

Send back completed form either in person, fax to 206-224-7997, or email customerservice@cabrinirx.com.

First Name:	Middle Name:	Last Name:
Name of Alternate/Preferred Contact (if not patient):		
Date of Birth (mm/dd/yyyy): / /	Gender (for insurance): ☐ Male ☐ Female	Primary Phone Number: ( ) -
SSN/Medicare #:		Secondary Phone Number: ( ) -
Email:		

Primary Address:

Street:	City:	State:	Zip:

Mailing or Delivery Address (if different from primary):

Street:	City:	State:	Zip:
☐ I will **pick up** my medications at the pharmacy, or a representative will pick them up for me.	☐ **Deliver** my medications to the address specified above		

Please choose *1* of the 4 following options:

☐ EZ Open Lids*	Signature:	Date:
☐ Regular Safety Cap Lids	Signature:	Date:
☐ Blister Pack*	Signature:	Date:
☐ Plastic Mediset* Initial purchase = $10	Signature:	Date:

☐ Transfer all my medications	Pharmacy:	
Allergies:	Describe Below:	☐ No Known Drug Allergies

Chronic Medical Conditions (Asthma, Diabetes, Depression, etc.)

List conditions here:

Insurance Information (please include picture of card if there are any questions)**

ID #:		RX BIN:	
Relationship Code:		RX Group:	

*Blister packaging and medisets are not childproof. Signature by patient or POA is required for any non-childproof container.

**Any copays or additional charges are due and payable by the 12th of each month. All payments are to be made directly to Cabrini Pharmacy Services. Accounts over 30 days delinquent shall bear interest at 18%. Should the account be referred to collection, the undersigned agrees to pay costs of collection, including reasonable attorney fees. Cabrini Pharmacy Services reserves the right to discontinue providing medications to any account that is over sixty (60) days delinquent. NSF check charges are $25.00 plus any collection costs.

By signing this agreement, I authorize Cabrini Pharmacy Services to bill Medicare or other insurances for the above patient if applicable. I also authorize Cabrini Pharmacy Services to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable of related services. By signing this agreement, the individual has acknowledged that they have received a copy of our privacy policies and has reviewed them. The individual accepts the terms of this agreement as stated above.