7455 S US HWY 1 TITUSVILLE, FL 32780

321-508-0999
Fax: 321-507-4715

Pharmacy Information

Client Name: ____ **DOB:**_________________________

CLIENT PHARMACY INFORMATION			
PRIMARY PHARMACY:			
PHONE: ____		FAX: _______________________________________	
DELIVERY INFORMATION			
Deliver to:	☐ HOME	☐ CURATIVE CARE CENTER (ROCKLEDGE) or (TITUSVILLE)	☐ Medical Provider :_____________________
DELIVERY REQUIREMENTS:			
FED EX: ☐ Checking this box authorizes receipt of medication in mail waiving need for signature			
Blister Pack or any other packaging requirements:			
Any callback or delivery precautions:			
Any other information: (ex. No Safety Caps)			

<u>Please Check ALL that apply:</u>

☐ Automatically refill my prescriptions before I run out of medicine

☐ **I prefer to pick up medications from the pharmacy directly**

I hereby authorize the Pharmacy to oversee and dispense my prescription medications as indicated above.

CLIENT OR GUARDIAN MUST SIGN TO ATTEST THAT INFORMATION ON THIS FORM IS CORRECT

CLIENT SIGNATURE:___________________________________ **TODAY'S DATE:** ________/_________/__________

<u>REMEMBER TO SEND COPY OF INSURANCE CARDS WITH THIS FORM TO PREFERRED PHARMACY</u>