SAWTOOTH MOUNTAIN CLINIC PHARMACY

CONFIDENTIAL PATIENT INFORMATION AND TRANSFER FORM - PLEASE FILLOUT THE FORM AND PRINT WHEN FINISHED - DELIVER OR FAX TO THE PHARMACY TO COMPLETE YOUR TRANSFER REQUEST

PATIENT INFO

LAST NAME: FIRST NAME: MI:

MAILING ADDRESS:

CITY: STATE: ZIP CODE:

HOME PHONE: MOBILE PHONE:

MAY WE LEAVE A MESSAGE?: _____ PREFER CALL OR TEXT?: _____

BIRTH DATE[MM/DD/YYYY]: SEX [SELECT]

DRUG ALLERGIES:

INSURANCE INFO

DO YOU HAVE PRESCRIPTION INSURANCE? _____

INSURANCE PROVIDER NAME: BIN #:

CUSTOMER ID#: GROUP#:

PHARMACY TRANSFER INFORMATION (*FILL OUT IF YOU NEED PRESCRIPTIONS TRANSFERRED FROM ANOTHER PHARMACY*)

PLEASE ALLOW 7-10 DAYS TO TRANSFER PRESCRIPTIONS. PHARMACY WILL CONTACT YOU WHEN YOUR PRESCRIPTIONS ARE READY.

PHARMACY NAME: PHARMACY PHONE:

PRESCRIPTION NUMBER(S)/NAME OF MEDICATION(S):

OTHER INSTRUCTIONS:

SAWTOOTH MOUNTAIN CLINIC PHARMACY WILL CONTACT YOUR PHARMACY TO OBTAIN ALL NECESSARY INFORMATION

PLEASE PRINT AND BRING FILL ED OUT FORM TO THE PHARMACY OR FAX IT TO THE PHARMACY AT: 218-877-8279