FAX OR ESCRIPT ALL PRESCRIPTIONS TO
**PRXP of CA**
4345 E Lowell Street, Suites C & D|Ontario, CA 91761

**Phone & Fax: 888-505-1485**

PRXP | PRxP OF CA PHARMACY

☐ **340B Regular** ☐ **PREP** ☐ **T&T**

**Clinic Name:** _____ **340B Eligible:** ☐ **Yes** ☐ **No**

**Today's Date:** _____ **PCP:** _____

## PATIENT INFORMATION (REQUIRED INFORMATION)

Patient's Last Name: First: Middle: Preferred: Birth Date: ___/___/____

_____ _____ _____ _____

Sex (Check One): ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Street Address: _____ P.O. Box: _____ City, State, Zip: _____

Home Phone: _____ Emergency Contact: _____ Emergency Contact Phone: _____

Any known allergies: _____

***Please attach copy of drivers license or photo ID**
☐ **Check to Indicate Copy Attached**

## CURRENT PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

## PRESCRIPTION INSURANCE INFORMATION *(ATTACH FRONT & BACK OF INSURANCE CARD)*

☐ **Check to Indicate Front/Back of Insurance Card is Attached**

Policy Insurance: _____ PCN: _____ BIN: _____

Subscriber's Name: _____ Rx Group Number: _____ Patient ID: _____

Patient Relationship to Subscriber (Check One): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

## DELIVERY INFORMATION *(CHECK ONE)*

☐ Patient's Address (Street Address: _____ City, State, Zip: _____)

☐ Prescriber's Address (Street Address: _____ City, State, Zip: _____)

☐ Other (Street Address: _____ City, State, Zip: _____)

## ACKNOWLEDGMENT FORM *(PLEASE SIGN)*

BY SIGNING BELOW, I AUTHORIZE PRXP OF CA TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRACTICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM.

_____ _____

*Patient/Guardian Signature* *Date*

**Licensed in CA*