FAX OR ESCRIPT ALL PRESCRIPTIONS TO
Broadway Family Pharmacy
510 Amsterdam Ave, STR1|New York, NY 10024-3935

Telephone: 212-724-1950
Fax: 212-724-1946

BFP | BROADWAY FAMILY 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 Name: _____ Middle Name: _____ Preferred Name: _____ Birth Date: ___/___/____

Sex (Check One): ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Pronouns: _____

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 BROADWAY FAMILY PHARMACY 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 NY, CT, NJ, DC, MD, GA, KS, MO, PA, WA, TX, NV, VA, OH, CA and IL*