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

Phone: 212-724-1950 | Toll Free: 888-609-2064
Fax: 212-724-1946 | Email: prxpny@340bpharm.com

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, AZ, CA, CT, DC, FL, GA, IL, IN, KS, MD, MN, MO, NE, NJ, NV, OH, PA, TX, VA, WA, and WI*