

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



**Toll Free Phone & Fax: 888-609-2064**  
**Email: prxpny@340bpharm.com**

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    Gender Identity:  Male     Female    Pronouns: \_\_\_\_\_  
 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 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, AL, AZ, CA, CT, CO, DC, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV and WY