



\*To fill out this form online, please scan the QR code.

**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: ny\_pharmacists@340bpharm.com

\*Licensed in NY, AK, AL, AZ, CA, CT, CO, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, ME, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV and WY

CLINIC NAME:	<input type="checkbox"/> 340B Regular	<input type="checkbox"/> PREP	<input type="checkbox"/> T&T
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TODAY'S DATE:	340B Eligible:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>DELIVERY INFORMATION</b>	PCP:
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<input type="checkbox"/> Patient's Address:
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<input type="checkbox"/> Prescriber's Address:
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<input type="checkbox"/> Other Address:
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<b>CURRENT PHARMACY INFORMATION</b>
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Pharmacy: _____	Phone: _____	Fax: _____
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Address: _____
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**PATIENT DEMOGRAPHICS (REQUIRED)**

Last Name:	First Name:	Middle Name:
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Preferred Name:	Birth Date: ___/___/____	Pronouns:
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Sex [Check One]: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other:
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Street Address:	P.O. Box	City, State, Zip:
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Phone Number: _____ (Home/Cell)	Emergency Contact: _____	Emergency Contact Phone: _____
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**\*Please attach copy of driver's license or photo ID front and back as well as Insurance Cards front and back (Including prescription benefits)**

Policy Insurance:	Patient ID:	Rx Group Number:
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PCN:	BIN:	Subscriber's Name:
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Patient Relationship to Subscriber [Check One]: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	<input type="checkbox"/> Check to Indicate Front/Back of Insurance Card is Attached
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**PATIENT CLINICALS (REQUIRED)**

**\*Please send additional sheet if needed for complete medication list**

Patient's Diagnosis [include ICD-10]:
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Patient's Other Medical Conditions [include ICD-10]:	<input type="checkbox"/> No other medical conditions
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Any known allergies or sensitivities:	<input type="checkbox"/> No Known Allergies
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Pertinent Medical History:	<input type="checkbox"/> No additional Information
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Is patient able to self-administer the medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", provide details:
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<b>PrEP</b> : Date of last negative result:	<b>HIV</b> : Current CD4 (T-cell) count:	<b>HIV</b> : Resistance test result:
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<b>HIV</b> : Date of last positive result:	<b>HIV</b> : Current viral load:	<b>HCV</b> : Current viral load:
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<b>HCV</b> : Genotype:	<b>HCV</b> : IL-28B:	<b>HCV</b> : Liver Fibrosis:
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<b>Other Medications Including OTCs &amp; Supplements</b>	<b>Dose, Route, Frequency</b>	<b>Diagnosis</b>

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:** \_\_\_\_\_

BY SIGNING BELOW, I AUTHORIZE BROADWAY FAMILY PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_