



*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

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

PATIENT DEMOGRAPHICS (REQUIRED)

Last Name:	First Name:	Middle Name:
Preferred Name:	Birth Date: ___/___/____	Pronouns:
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:	
Street Address:	P.O. Box	City, State, Zip:
Phone Number: _____ (Home/Cell)	Emergency Contact:	Emergency Contact Phone: _____
*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:
PCN:	BIN:	Subscriber's Name:
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		

PATIENT CLINICALS (REQUIRED)

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

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

<i>Other Medications Including OTCs & Supplements</i>	<i>Dose, Route, Frequency</i>	<i>Diagnosis</i>

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:** _____