



Patient Profile Form

Insured Family Member

Last Name: _____ First Name: _____ M.I.: ___ DOB: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Mobile: _____ Work: _____
 Drug Allergies: _____ Medical Conditions: _____

Spouse

Last Name: _____ First Name: _____ M.I.: ___ DOB: _____ Sex: M / F
 Home Phone: _____ Mobile: _____ Work: _____
 Drug Allergies: _____ Medical Conditions: _____

Dependent

Last Name: _____ First Name: _____ M.I.: ___ DOB: _____ Sex: M / F
 Home Phone: _____ Mobile: _____ Work: _____
 Drug Allergies: _____ Medical Conditions: _____

Dependent

Last Name: _____ First Name: _____ M.I.: ___ DOB: _____ Sex: M / F
 Home Phone: _____ Mobile: _____ Work: _____
 Drug Allergies: _____ Medical Conditions: _____

Prescriptions Enclosed (New/Refills)

Name: _____	DOB: _____	Refill #'s/New Rx: _____
Name: _____	DOB: _____	Refill #'s/New Rx: _____
Name: _____	DOB: _____	Refill #'s/New Rx: _____
Name: _____	DOB: _____	Refill #'s/New Rx: _____

Total Prescriptions Enclosed: New: _____ Refills: _____

Please Contact us at 1-866-287-9885 to arrange a form of payment to avoid delays in shipping your prescription orders.

Completed Forms can be returned to: **ProAct Pharmacy Services; 1226 US Hwy 11; Gouverneur, NY 13642**

Receipt of Privacy Practices

I acknowledge the receipt of the ProAct Pharmacy Services Notice of Privacy Practices

 Signature of Insured Family Member Printed Name of Insured Date