New Patient Enrollment Form
4101 Wagon Trail Ave,
Las Vegas, Nevada 89118
Phone: 702-576-9545
Fax: 702-946-0353

Patient Information:

Date:_____Patient SS#:_____DOB:_____ Female / Male

First Name:_____Last Name:_____

Address:_____

Home Phone:_____Cell Phone:_____

Emergency Contact:_____Phone: _____

Guardian:_____Phone:_____

(GUARDIAN IS PERSON WHO IS IN CHARGE OF COPAYMENTS AND STATEMENTS**)**

Insurance Information:

Primary Insurance:_____ Secondary Insurance:_____

Insured:_____Insured:_____

RX BIN:_____RX BIN_____

PCN:_____PCN:_____

ID# : _____ID#:_____

RX Group:_____RX Group:_____

Medication List :

Current Pharmacy:_____ Pharmacy Phone:_____

I (Patient name)_____hereby acknowledge Patient Care Pharmacy to provide me with all my pharmaceutical needs and I am responsible for all copayment and Statments.

Patient Signature: _____Date_____