



Confidential Enrollment Form

Contact Information

Last Name _____ First Name _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____

*** PLEASE PROVIDE PHYSICAL ADDRESS, NOT PO BOX ***

Date of Birth ____ / ____ / ____ Gender Male Female
 Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____
 Email _____

Preferred Method of Contact

May we leave you messages regarding your medications? Please check yes or no for each method of contact:

Home phone Yes No Cell phone Yes No
 Email Yes No Text message Yes No

Allergies

Are you allergic to any medications? Yes No

If yes, please list medication(s) here: _____

Maintenance Medication Refills

Would you like to enroll in our automatic refill program? Whenever your refills expire, we will automatically process a refill request and will have your prescription ready. Yes No

Pick-up and Delivery

We offer free delivery or USPS shipping to **all** San Diego County and Imperial County addresses. (PO BOX OK)

Would you like to receive your medications via pick up delivery or mail? (check one)

If you would like your medication(s) delivered/shipped to an address **other than home**, please notate here:

Location Name _____
 Address _____ City _____ State _____ Zip _____

Insurance Information

Insurance card attached

Insurance Carrier _____

Subscriber Number _____ Group Number _____

Emergency Contact Information

Last Name _____ First Name _____

Relation _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Authorization to receive medication

I authorize _____ to pick up/receive medications on my behalf.

 Signature

 Date