

# DrugSource, Inc. Patient Profile Registration

P.O. Box 1366 - Elk Grove Village, IL 60009-1366 - Fax: (847) 258-1913

Email Address:		Company Name & Group#:	
Employee's Name:		Employee's Date of Birth:	
Employee's Address:		Male or Female:	
Employee's ID Number#:		Day Phone Evening Phone	
Physician Name:		Physician Phone Number:	

Employee's Allergy and Medical Condition (write none if none)

Are you pregnant at this time? Yes No (Circle one)

Patient Name	Relationship	Date of Birth	Sex	Doctor's Name/Phone
Allergy and Medical Condition:				
Allergy and Medical Condition:				
Allergy and Medical Condition:				

### Employee's Credit Card Information

Card Type		Card Number		Exp. Date	
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### Generic Medication Information

Yes, I authorize DrugSource to dispense generic medications.

No, I do not authorize DrugSource to dispense generic medications and understand that refusal of generic medication may impact my co-payment.

I would like a call from a pharmacist to discuss any medical questions I have.

I certify the information on this form is correct. I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, and sponsor in accordance with the Health Insurance Portability and Accessibility Act(H.I.P.A.A.).

Signature:	Date:
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