Confidential Patient Profile

Please Print or Type | Allergies | Health Conditions

ENTER FIRST AND LAST NAME	DATE OF BIRTH	GENDER (M OR F)	NONE	AMPICILLIN	ASPIRIN	CEPHALOSPORINS	CODEINE	ERYTHROMYCIN	PENICILLIN	SULFA	TETRACYCLINES	THYROID	DIABETES	GLAUCOMA	HIGH BLOOD PRESSURE	INTESTINAL DISORDERS	HEART CONDITIONS	LUNG CONDITIONS	OTHER ALLERGIES OR HEALTH CONDITIONS
SUBSCRIBER'S NAME:																			
SPOUSE'S NAME:																			
CHILD'S NAME:																			
CHILD'S NAME:																			
CHILD'S NAME:																			

State/Region Code

- ☐ **PAZ** Arizona
- ☐ **PCC** California
- ☐ **PCD** Colorado
- ☐ **POK** Oklahoma
- ☐ **PCO** Oregon
- ☐ **PNV** Nevada
- ☐ **PTX** Texas
- ☐ **PCW** Washington
- ☐ **PAP** Asia Pacific

Only complete for your first order or if your information has changed. Mail to: Prescription Solutions®, P.O. Box 509075, San Diego, CA 92150-9075

Please complete this form and return in the attached envelope. Please make checks payable to Prescription Solutions. To allow us to monitor for potential drug interactions, please indicate any drug allergies, health conditions or chronic diseases on reverse side. Please print or type.

PLEASE SELECT METHOD OF PAYMENT – PLEASE DO NOT SEND CASH – ENCLOSE COPAYMENT FOR EACH PRESCRIPTION ORDERED

❑ CHECK OR MONEY ORDER (Payable to Prescription Solutions) **–or–** CREDIT CARD (Select one) ❑ Mastercard ❑ VISA ❑ DISCOVER ❑ AMEX

CREDIT CARD# _____ EXP. DATE (MM/YY): _____ CARD HOLDER NAME: _____ PRINT NAME

NUMBER OF PRESCRIPTIONS ENCLOSED: _____ TOTAL AMOUNT ENCLOSED: $ _____ SIGNATURE

Subscriber ID Number _____

PHYSICIAN NAME: _____ PHYSICIAN PHONE NUMBER: _____

SUBSCRIBER NAME: _____ GROUP NAME: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

I hereby certify the information on this form is correct. I assume financial responsibility for charges not payable or allowable by PacifiCare. Payment in excess of amount due should be applied to my account balance. If method of payment is not indicated, I authorize Prescription Solutions® to apply the charges to my credit card on file.

Signed: _____ REQUIRED Phone: (_____)_____ DAYTIME PHONE Date: _____