MedsPlus
New Customer Enrollment Form

REQUIRED DOCUMENT 2 OF 2

Customer Information

Last Name	*First Name*	*Middle Initial*	*Date of Birth*
Street Address		*Apt./Unit #*	*Social Security Number*

City	*State*	*ZIP*	*Telephone*	☐ *Male* ☐ *Female*

Allergies to Medications	*Diagnosis*

Assisted Living Information (if applicable)

Move In Date:	***Preferred Start Date for Medications:***
Moving from: ☐ Personal Residence ☐ Hospital:_____ ☐ Rehab:_____ ☐ Other:_____	***Will you receive assistance with your medication?*** ☐ **YES** ☐ SAMM ☐ LMA ☐ **NO** Independent with medication

Health Care Provider Information

	Name	***City & State***	***Contact Info***
Primary Care			*Phone:*
			Fax:
Other	*Specialty:*		*Phone:*
			Fax:
Other	*Specialty:*		*Phone:*
			Fax:

Prescription Drug Insurance Coverage

Please attach a copy of prescription insurance card(s). If there is more than one coverage type, please attach on a separate sheet.

Insurer Name	*Relationship to Policyholder*	*Person Code/Suffix (if applicable)*

ID Number	*Rx Group*	*RxBIN (if listed)*	*RxPCN (if listed)*

Medicare Information

Medicare ID Number

Family/Caregiver Contact Information

	Name	***Relation***	***Contact Info***
Billing Contact			*Phone:*
			Email:
Health Care Contact			*Phone:*
			Email:

Previous Pharmacy

Name	*Phone #*

Authorization

By signing below, I authorize enrollment in the MedsPlus medication management program. I understand that I may cancel membership in MedsPlus at any time by providing written notice to Eaton Apothecary. As a member of MedsPlus, I agree to pay the monthly membership fee that will be included on my monthly billing statement ($24 as of 1/2015). I understand that the Medicine-On-Time® packaging system is not a child proof system and I accept full responsibility for keeping these medication packages in a safe place away from children or other people not intended to take them. Lastly, I acknowledge receipt of Eaton Apothecary's Notice of Privacy Practices and understand I may access the Notice at www.eatonapothecary.com/privacy.

Signature of Patient or Patient's Personal Representative:_____

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Patient Information			
Last Name	*First Name*	*Middle Initial*	*Date of Birth*
Allergies to Medications			

Medication List *			
Medication	*Strength*	*Directions*	*Dosing Times*

ACCORDING TO STATE LAW, ALL PRESCRIPTIONS WILL BE FILLED GENERICALLY UNLESS "NO SUBSTITUTION" IS INDICATED

MD Signature:_____ Refillable until:_____

REFILLS WILL BE GOOD FOR ONE YEAR UNLESS OTHERWISE INDICATED

*** If more space is required, please attach an additional sheet of paper with remaining information**

Please provide written prescriptions for all CII-CV medications to pharmacy.