Pharmacy Care of Tennessee

NEW PATIENT ENROLLMENT

Name:		
Date of Birth:	**SSN:**	**Phone:**
Current Address:		
City:	**State:**	**Zip Code:**
Drug Allergies:		
Insurance:	**ID#**	**Rx BIN**
Rx GROUP	**Rx PCN**	

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS, OTC PRODUCTS, VITAMINS AND/OR HERBAL SUPPLEMENTS

Rx#	Medication	Pharmacy Name & Phone Number

Do you want to receive email or text prescription alerts? Yes / No

Email address:

Mobile number / carrier:

PAYMENT INFORMATION FOR CONVENIENT RX REFILLS & DELIVERIES

Card type (circle one) Visa Mastercard Discover		
Credit card number		**CID#**
Expiration date		

PCTN has permission to use this card for future orders: Yes No

I authorize this charge and future prescription charges

SIGNATURE

This form serves as a limited power of attorney, is specific to and only for the purpose of providing signatures for the receipt of medicines from PCTN. This agreement gives PCTN's representatives power to sign my name to the signature logs for receipt of my medicines. I have received a copy of PCTN's "Notice of Privacy Practices."

Patient Signature	Date

Thank you for letting our family take care of your family.

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