



635 Main Street  
Green Bay, WI 54301

Phone (920) 437-0206  
Fax (920) 437-0276

## NEW PATIENT INFORMATION FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ Allergies \_\_\_\_\_

Primary MD \_\_\_\_\_ Other MD \_\_\_\_\_

Previous Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

- YES, a copy of my prescription card is enclosed *(Please photocopy both sides of card)*
- NO, a copy of my prescription card is not attached *(Please provide the following prescription insurance Information)*

Name of Plan \_\_\_\_\_ Phone # \_\_\_\_\_

BIN # \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Person Code \_\_\_\_\_ PCN # \_\_\_\_\_

SSN# \_\_\_\_\_

### **STAFF USE ONLY:**

BLISTER PACK START DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

PLEASE CHECK (x) ONE OF THE FOLLOWING:

- Signed Rx ordered included
- Orders included; please obtain MD signature
- No Rx orders available; please call MD
- Please transfer Rx's from pharmacy listed above

Do medications need to be repackaged for the resident?  YES  NO  
*(If yes, please forward repackaging procedure and fee schedule)*

**FAXED TO STREU'S**

Date \_\_\_\_\_

Time \_\_\_\_\_

Staff Initials \_\_\_\_\_

**PHARMACY STAFF:** Enter all information above upon receipt.

