



**Patient Information**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Name (if patient is a family member): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number (Mobile/Home): \_\_\_\_\_ Phone Number (Work): \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Location: \_\_\_\_\_ Employee #: \_\_\_\_\_ Affiliate ID: \_\_\_\_\_

Allergies (include medication name & reaction): \_\_\_\_\_

I will pick up prescriptions at the pharmacy  I want my prescriptions delivered to my work (UPH employees)

**Billing Information**

Pharmacy Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

BIN Number: \_\_\_\_\_ PCN Number: \_\_\_\_\_

Copay Payment (Check One):

\_\_\_\_ Payroll Deduct

\_\_\_\_ Charge to the credit card, FSA, or HSA (Pharmacy will contact you for card information)

**Release**

I give permission to UnityPoint Health – Ankeny Medical Park Pharmacy employees to:

- Deliver prescriptions for myself and my family members to my place of employment. The prescription(s) may be left with either the patient, patient caregiver, or one of the authorized officials listed in Appendix A.
- Update my preferred pharmacy in the electronic health record.
- Contact my provider for additional refills if needed.
- Bill my insurance plan and selected payment method for any copays.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*Please complete the Prescription Transfer Form on the back**

# Prescription Transfer Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medication Name	Strength	Directions	Quantity Per Fill	Prescriber Name	Rx Number	Date Next Fill is Needed

**Would you like your medications to be automatically filled (Autofill)?** YES NO

**Would you like all of your routine medications to filled at the same time (MedSync)?** YES NO

**Would you like to receive notifications through MyUnityPoint when your prescriptions are ready?** YES NO

If yes, please include your preferred contact method:

Email address: \_\_\_\_\_

Text message notifications: \_\_\_\_\_

**Please return this form to Ankeny Medical Park Pharmacy by one of the following methods:**

In person or by mail: 3625 N Ankeny Blvd, Ste A; Ankeny, IA 50023

Fax: 515-446-2691