UnityPoint Health

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: _____

Allergies (include medication name & reaction): _____

Billing Information

Pharmacy Insurance ID Number: _____ Group Number:_____

BIN Number: _____ PCN Number: _____

Copay Payment:

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

Release

I give permission to UnityPoint Health Moline Trinity Hospital Outpatient Pharmacy employees to:

- 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

Please return this form to the Moline Trinity Hospital Outpatient Pharmacy by one of the following methods:

In person or by mail: Trinity Hospital Outpatient Pharmacy, 500 John Deere Rd, Moline, IL 61265
located through Main Entrance near Registration

Email: Linda.Wessel@unitypoint.org

Fax: 309-779-5018