



Date: \_\_\_\_\_

# NEW RETAIL PATIENT

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

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

Patient Type (check one):      Resident of Delmar Gardens Villa  
Employee of Delmar Gardens

I authorize Corum to deliver my prescription to the following Delmar Gardens location (place of residence or place of employment):  
\_\_\_\_\_

*\*\*Please note: for Villa residents, medications will be delivered and signed for by the front desk.*

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

SSN: \_\_\_\_\_ Safety Caps:      YES      NO

**Please fax a copy of your insurance card to Corum (636-733-7334).**

The billing statement should be sent to:      The Patient      Other (*information below*)

Bill to: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Billing address: \_\_\_\_\_

**Additional family members who will be filling medications with Corum:**