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:

Name: _____   DOB: _____   Sex: _____

Allergies: _____

Name: _____   DOB: _____   Sex: _____

Allergies: _____