D-H SPECIALTY PHARMACY MAIL-ORDER ENROLLMENT

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___

Date of Birth: ____/____/_____ E-Mail:_____

Physical Address: _____ Apt #:_____

City: _____ State: _____ Zip Code:_____

Home Phone: ( ) - Work Phone: ( ) - Cell Phone: ( ) -

Preferred Contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail

Drug Allergies: _____

_____

SHIPPING INFORMATION

All medication will be shipped via USPS unless otherwise indicated. If you require FedEx delivery, please indicate in the 'Additional Information' on the following page. A signature is required upon delivery for applicable items. Refrigerated items will be delivered 'Priority Overnight' via FedEx. If you request a 90 day supply of your medication, please contact your provider's office to send a 90 day supply prescription to the D-H Pharmacy.

Shipping Address: _____ Apt #:_____

City: _____ State: _____ Zip Code:_____

Contact Phone: ( ) -

I would like my prescriptions to be mailed (check one): ☐ Always ☐ Only When Requested