RESIDENT ENROLLMENT FORM

RESIDENT INFORMATION

RESIDENT NAME ____
[FIRST] [MIDDLE INITIAL] [LAST]

SSN# ______-______-______ **Medicare ID#** ______________________________

DOB ______/______/______ □ MALE □ FEMALE

COMMUNITY NAME ______________________________ APT# __________

PRIMARY CARE PHYSICIAN __________________________ PHYSICIAN PHONE __________

MEDICAL DIAGNOSIS __________________________ ALLERGIES ______________

PRESCRIPTION DRUG INSURANCE

PRESCRIPTION INSURANCE PLAN ______________________ CARDHOLDER ID# ____________

RX GROUP# ______________ RX BIN# ______________ PCN# ______________

RELATIONSHIP TO CARDHOLDER: □ SELF □ SPOUSE □ OTHER ______________________

A PHOTO COPY OF THE INSURANCE CARD [FRONT AND BACK] MUST BE INCLUDED FOR THE PHARMACY TO PROCESS INSURANCE

RESPONSIBLE PARTY INFORMATION

PRIMARY ______________________________ RELATIONSHIP TO RESIDENT ______________
[FIRST] [LAST]

PHONE ______________ □ HOME □ CELL EMAIL ______________________________

ADDRESS* ____
[STREET] [CITY] [STATE] [ZIP CODE]

**MONTHLY STATEMENTS WILL BE MAILED TO THIS ADDRESS*

SECONDARY* ______________________________ RELATIONSHIP TO RESIDENT ______________
[FIRST] [LAST]

PHONE ______________ □ HOME □ CELL EMAIL ______________________________

**SECONDARY MUST BE COMPLETED IF RESIDENT IS LISTED AS PRIMARY CONTACT*