Scribner Drugstore - PakMyMeds™ Enrollment Form

Patient Information

Full Name: _____ Birthdate: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Allergies: _____

Physician: _____ Other Contact Name: _____ Contact Phone: _____

	YES	NO	
Does patient receive Home Health Care?	☐	☐	If yes, contact info:
Do we need to transfer prescriptions?	☐	☐	If yes, pharmacy & phone:

Medicare A/B (Red, White, Blue Card) ID No.: _____

Primary Insurance: _____ RxBIN: _____ PCN: _____ ID#: _____

Secondary Insurance: _____ RxBIN: _____ PCN: _____ ID#: _____

Medication List

Include routine vitamins/supplements

Medication:	Dose Time(s):	Fast	Morn	Noon	Aftn	Eve	Bed	How much on hand? Quantity:

☐ additional meds listed pg 2 ☐ generic times?

Pick-Up/Delivery Details

	WILL CALL	DELIVERY	MAIL
Delivery type?	☐	☐	☐

Anticipated Start Date: _____

Special Instructions: _____

Disclaimer and Signature

Scribner Drugstore offers this complimentary medication packaging service to our patients in an effort to simplify the managing of their medication regimen, maintain their independence, and improve their quality of life. When transferring to this program, it is important to understand, we can only package the medications we dispense, and that not all medications may be covered initially if they were filled recently at another pharmacy. In addition, any prescriptions that are received after a patient's medications have been packed, will be dispensed in a bottle. There are limited circumstances to open packaging and make changes once the packaging is complete. *By enrolling in Scribner Drugstore MedPaks I understand and accept Non-Child Resistant Packaging as defined by the Poison Prevention Act. Please keep all medications out of the reach of children.*
I agree with these guidelines:

Patient or Caregiver: _____ Date: _____

Patient Name: Patient Birthdate:

Medication List (Continued…)

Include routine vitamins/supplements		Fast	Morn	Noon	Aftn	Eve	Bed	How much on hand?
Medication:	Dose Time(s):							Quantity:
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Medication:	Dose Time(s):							Quantity:

Scribner Drugstore PakMyMeds™ Release Form

I _____ have enrolled in
(Name)

Scribner Drugstore's MedPaks Service as of _____.
(date)

Please • update Scribner Drugstore as my pharmacy of choice in my chart
• send any new prescriptions or prescription renewals to Scribner Drugstore
• make them aware of any dose changes or medications that are being discontinued

_____
(Signature)

SCRIBNER
DRUGSTORE

402-664-3133 p
402-664-3074 f