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MADISON PHARMACY
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973-377-1960 (fax)

RETURN THIS FORM TO
MADISON PHARMACY

FDU

MADISON PHARMACY COLLEGE PROGRAM REGISTRATION FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
Dorm Building & Room # _____ Cell Phone #: _____
(if available-optional) _____
Sex: M _____ F _____

ALLERGIES

(Yes) Drug Allergies Please List: _____
(No) Drug Allergies _____

PRESCRIPTION PLAN INSURANCE CARD

***Please attach a legible copy front and back of your Prescription Plan Insurance Card or supply the following:**
Bin#.....PCN#.....Group#.....ID#.....

Credit Card Charge Accounts & Home Information

Account? Yes No
Type of Credit card Visa Amex Discover Mastercard(circle one)
Name on Card _____
Billing Address of card _____ Credit Card # _____
_____ CVV Code _____
_____ Exp. Date _____
Billing Zip _____ Home Phone # _____

Name as it appears on card _____ I acknowledge and assume responsibility and grant authorization for Madsion Pharmacy to charge the above credit card. I also acknowledge responsibility for the cost of any medication not covered by my insurance company, for any medication that Madison Pharmacy cannot get reimbursement for, as well as any co-pays and deductibles and charges for requested OTC / Sundries which I agree will be billed to my credit card by Madison Pharmacy. I authorize Madison Pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. As per our HIPAA agreement all personal information received will be solely maintained for the purposes of dipensing prescriptions and insurance collection.

Signature of Guarantor: _____