Visit Us At
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MADISON PHARMACY
66 Main St.
Madison, NJ 07940
973-377-0075
973-377-1960 (fax)

RETURN THIS FORM TO MADISON PHARMACY

DREW

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** **Mastercarc** ***(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: ______________________