New Customer Form

Please print out this form, complete
it in dark-colored ink, and fax it to
305.442.8185 or scan it and e-mail
it to: cgrx1@yahoo.com.
Ph: 305.442.0211
Ph: 1.877.442.8702
Coconut Grove Pharmacy
3001 SW 27th Ave.
Coconut Grove, Fl 33133

1. Patient Information:

Patient Name_____
Date of Birth____/____/____
Home Phone (_____)_____
Work Phone (_____)_____
Address_____
City_____State____
_ Zip_____

Allergies_____

Phone number where you can be reached
(_____)_____

2. Prescription Info:

[ ] I have one or more new prescriptions to fill.

Please have your doctor call or fax us the prescription(s). If you have the prescription you may fax it to us so that we can verify it with your doctor and start filling the order. Please be sure to give us the original prescription when we deliver the order or you pick it up in person at the pharmacy.

[ ] Please transfer my prescription(s) from my old pharmacy.

Name and phone number of previous pharmacy:
_____

Name and prescription number of drug at previous pharmacy:

_____

3. Retrieval Method:

Please check one of the following:

[ ] The prescription will be picked up.
[ ] Please deliver.
[ ] Please ship/mail.

Delivery/ Shipping Address (if different from above):
Address_____
City_____ State_____ Zip_____
Phone (_____)_____

4. Insurance Information:

Please fax a copy of your insurance card.
Insurance Company_____
Social Security #_____
PCN # or BIN #_____
Group #_____
ID/Member #_____

5. Billing Information:

Type of Credit Card:

[ ] Visa [ ] Mastercard [ ] Discover [ ] Amex

Name as it appears on the card:

_____

Credit Card#_____

Exp Date ____/____/____

CVV2*_____

*3- digit code printed on back of MasterCard, Visa, and Discover cards.

*4-digit code printed (NOT embossed) on front of American Express card.

6. Authorization:

I authorize all prescriptions charged for amounts not covered by my insurance plan to be billed to the above charge card number.

Cardholder Signature_____

Date____/____/____