



New Patient Enrollment Form

www.a-med.com

Please complete and fax this form and **prescription** to 866.539.1092
OR call the **A-Med Specialty Pharmacy Hotline** at 800.228.3643

CLIENT Information

Client Name: _____ D.O.B.: ____/____/____

Social Security #: _____ - _____ - _____ Phone (day): (____) _____

Best time to call: _____ am or _____ pm Phone (eve): (____) _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Medicaid #: _____ ADAP #: _____

Other Insurance: _____ ID #: _____ Group #: _____

Please include copy of insurance card - front and back

Date Medication is Needed: ____/____/____ Best Delivery Time: _____

Special Delivery Instructions: _____

Any Known Allergies: _____

DOCTOR Information

Doctor Name: _____ Hospital/Clinic: _____

DEA License #: _____ State License #: _____

Phone: (____) _____ Fax: (____) _____

Address: _____ Ste. #: _____

City: _____ State: _____ Zip: _____

Special Instructions: _____

Transferring Pharmacy: _____ Phone: (____) _____

Referral Source: _____

Authorized Signature: _____ Date: _____

