New Customer Form

Patient Information

Name: ___________________________________ Date of Birth: ___________ Gender: ___________

Address: ____

City: _____________________________________ State: ________________ Zip Code: __________

Phone: ___________________________________ Alt. Phone: ________________________________

If applicable, Patient Caregiver/POA: ____ Contact Phone Number: ______________________

Credit or Debit card information *(optional)* Card #: __________________________________ Exp: ____ CVV: ____

By providing my credit or debit card information above and by signing my name at the bottom of this form, I authorize Reedsburg Area Medical Center Pharmacies to charge my pharmacy expenses to my debit or credit card. I authorize the pharmacy to charge my debit or credit card before the medication is released to myself or authorized agent. If I choose not to provide this information, the pharmacy will collect payment from myself or an authorized agent at the time when my medication is released.

Insurance Information

Do you have prescription insurance? ☐ Yes(name of carrier): ____________________________ ☐ No

If yes, please provide copy of insurance card or provide the information in the fields below

BIN#__________ PCN#_________ ID# ________________ Group# _____________ Person Code:_______

Secondary Insurance

☐ Medicare ID: __________________________

☐ Medicaid ID: __________________________

Medical Information

Medications: *Please provide a current list of prescription, over the counter medications and supplements.*

Drug/Non-drug Allergies? ☐ Yes: ____ ☐ No

Where do you get your prescriptions filled?

☐ RAMC Community Pharmacy/Viking Pharmacy

☐ Another pharmacy

If another pharmacy:

Pharmacy Name: ______________________________

Pharmacy Phone: ______________________________

I understand that I am fully responsible for understanding and verifying my insurance benefits/coverage for prescription medications and that I am personally responsible for any costs that are not covered under my prescription benefit plan. I also understand that it is my responsibility to communicate any changes in my medications and any changes to my prescription benefit plan to the Reedsburg Area Medical Center Pharmacy staff.

By signing below, I certify that I have read and agree with the above terms and conditions.

Member Signature: x_____________________________________ Date: _______________________

Fax to Community Pharmacy at 608-524-8372
Email to RAMC Community Pharmacy at communitypharmacy@ramchealth.org
Drop off or mail to RAMC Community Pharmacy; 1900 N Dewey Ave. Reedsburg, WI 53959