genoa healthcare

Consumer Enrollment Form

Section 1. Consumer Information

Consumer Name _____ _____ _____
Last *First* *M.I.*

Social Sec. # _____ Date of Birth _____ Sex: M / F

Mailing Address _____
Street *City* *State* *Zip*

Shipping Address _____
Street *City* *State* *Zip*

Email Address _____ Phone _____

Section 2. Insurance Information

Payee/Billing Information - please provide a copy of Insurance Card

Billing Address _____
Street *City* *State* *Zip*

Primary Insurance Information

Policy Holder Name _____ _____ _____
Last *First* *M.I.*

Social Sec. # _____ Date of Birth _____ Relationship _____

Insurance Company _____ Policy/Group# _____

BIN _____ PCN _____ ID# _____

Secondary Insurance Information

Policy Holder Name _____ _____ _____
Last *First* *M.I.*

Social Sec. # _____ Date of Birth _____ Relationship _____

Insurance Company _____ Policy/Group# _____

BIN _____ PCN _____ ID# _____

Section 3. Brief Medical History

Diagnosis/Medical Conditions, please describe: _____

Medication Allergies: Y / N If yes, please describe: _____

Current Medications: _____

Section 4. Prescription Packaging

Which type of packaging would you prefer?

Vial - Child Resistant Y / N 30-Day Card Y / N Dispill Y / N Other Y / N

Section 5. Refill Reminder Program

Genoa Healthcare, in order to provide prompt and convenient service to all of our consumers and to better assist our consumers with their medication therapy, has the ability to contact a consumer, guardian, or caregiver by phone when a prescription refill is due. With your consent, we can then fill the prescription and have it ready for pickup, or we can mail the prescription out to you at no extra charge.* This service is on a voluntary basis.**

I would like to enroll in the program: Y / N

*Certain restriction apply on certain medications, please consult with the Pharmacist to see if you qualify.
**Genoa Healthcare will not share any information obtained and will not use it for any other purpose, but for the Refill Reminder Program.

I understand and acknowledge that I am personally responsible for the charges at this site and that Genoa Healthcare Company will bill my insurance as a courtesy. In the event of non-payment, I understand that I will be responsible for any outstanding balance.

_____ _____
Consumer/Responsible Party Signature **Date**