

Patient information

Complete what you know. Your pharmacy will confirm any missing details with you.

Chosen OnPoint pharmacy**Patient full name****Date of birth****Phone number****Email (optional)****Address, city, state and ZIP**

Primary prescription insurance

Plan name**Member / subscriber ID****RxBIN (6 digits)****RxPCN****RxGroup / group ID**

Secondary prescription insurance (if applicable)

Plan name**Member / subscriber ID****RxBIN (6 digits)****RxPCN****RxGroup / group ID**

Bring both sides of each card. Write "Not listed" if your card has no RxPCN or RxGroup.

If you have no insurance or need help finding these details, tell the pharmacy.

An insurance card does not confirm network participation, benefits or payment.

Keep completed forms private. Do not send health information to a general contact inbox.

Health and medication information

For pharmacist review. Add your medication list on the separate template, or bring your own list.

Patient full name

Date of birth

Allergies and reactions (write none or not sure when appropriate)

Conditions or recent medication changes you want to discuss

Prescriber / practice

Practice phone

Caregiver name and relationship (optional)

Caregiver phone (optional)

Language, contact preference, pickup / delivery needs or questions

Your pharmacy will verify authority before sharing information with a caregiver.

This form does not enroll you in messaging or acknowledge a Notice of Privacy Practices.

Ask your pharmacy for its current privacy notice and any required consent process.

Need medication urgently or running out? Call the pharmacy. For a medical emergency, call 911.