BOUVIER
Pharmacy & Home Medical Solutions
Family Owned Since 1900

New Patient Enrollment Form

Preferred Start Date

Personal Information					
Last Name	First Name		Facility Name (if applicable)		
Street Address	City		State	Zip	
Daytime Telephone	Social Security Number		Date of Birth	Sex: Male / Female	

Primary Care Provider			
Last Name	First Name	Telephone	
Street Address	City	State	Zip

Other Provider			
Last Name	First Name	Telephone	
Street Address	City	State	Zip

Allergies to Medications

Medication List (Please provide written prescriptions if available, or request MD to send to pharmacy)			
Medication	Dose	Direction	Dose Times

Prescriber Signature (if applicable) _____

Continued on Page 2

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Primary Contact			
Name	Phone	Relation	
Address	City	State	Zip
Email	Use this as billing address? Y/N		

Previous Pharmacy (If known)	
Name	Phone

Prescription Drug Coverage		
Insurer Name	Relationship to Policy Holder	
Identification number	Rx Group #	
Medicare ID Number	RxBIN (if listed)	RxPCN (if listed)

If possible, please attach a copy of the prescription insurance card or cards. If there is more than one coverage type, please attach additional information on a separate sheet of paper.

Payment Policy:			
For all delivery customers a current form of payment must be provided below. We will process payment once a month and charge details will be sent to the billing address noted. If an outstanding balance is 90 days past due, medication services will cease.			
Credit Card Type: MC/Visa/Amex/Disc	CC#:		Exp Date:
Billing Zip Code	CVV:	Name on Card:	
FOR AUTO-PAY VIA E-CHECK	BANK ROUTING #:	ACCOUNT #:	

Agreement to Payment and Waiver of tamper proof packaging

I fully understand Bouvier Pharmacy's payment policy, specifically that all Co-Payments, Deductibles, or non-covered items or services are the responsibility of the undersigned and will be payable monthly. I further understand that this is not a child proof system and I accept full responsibility for keeping these medications in a safe place away from children or other people not intended to take them.

_____ _____

Signature of Patient or Patient's personal representative *Date*

_____

Printed Name

515 Lincoln Street, Marlborough, MA
Phone/Fax: 508-485-0432 www.bouvierpharmacy.com