HIGH STREET DISCOUNT PHARMACY

PATIENT INFORMATION *(PLEASE PRINT)*

BENEFICIARY INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address

City | State | Zip

Place of Residence (i.e. Beneficiary Home, Caregiver, LTC, SNF, w/Family) | Residence Phone Number

Emergency Contact Person Name | Emergency Contact's Phone Number

Caregiver's Name | Caregiver's Phone Number

PHYSICIAN INFORMATION

Physician's Name

Office Address

City | State | Zip

Office Phone Number | Date of Last Office Visit

INSURANCE INFORMATION

Medicare Number | Part B Effective Date

Name of Secondary Insurance | Phone

Policy or ID Number | Group Number

Name of Policyholder (if other than Beneficiary)

Beneficiary Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child

Policyholder Date of Birth | Policyholder Social Security Number

Employer's Name

Employer Address

City | State | Zip

I understand that this information is vital for processing Beneficiary prescriptions and will remain confidential.

Beneficiary or Caregiver's Signature | Date

Beneficiary or Caregiver's Printed Name