PROACT PHARMACY SERVICES

Pharmacy Benefit Dimensions®
An Independent Health company

Patient Profile Form

Insured Family Member

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F

Address: _____ City:_____ State:_____ Zip:_____
Home Phone: _____ Mobile: _____Work:_____
Drug Allergies: _____Medical Conditions: _____

Spouse

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F
Home Phone: _____ Mobile:_____ Work:_____
Drug Allergies: _____Medical Conditions: _____

Dependent

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F
Home Phone: _____ Mobile:_____ Work:_____
Drug Allergies: _____Medical Conditions: _____

Prescriptions Enclosed (New/Refills)

Name: _____ DOB: _____ Refill #'s/New Rx:_____
Name: _____ DOB: _____ Refill #'s/New Rx:_____
Name: _____ DOB: _____ Refill #'s/New Rx:_____
Name: _____ DOB: _____ Refill #'s/New Rx:_____

Total Prescriptions Enclosed: New: _____ Refills: _____

Please Contact us at 1-888-425-3301 to arrange a form of payment to avoid delays in shipping your prescription orders.

Completed Forms can be returned to: **ProAct Pharmacy Services; 1226 US Hwy 11; Gouverneur, NY**

13642 Receipt of Privacy Practices

I acknowledge the receipt of the ProAct Pharmacy Services Notice of Privacy Practices

Signature of Insured Family Member Printed Name of Insured Date

_____ _____ _____