

Transfer Information Form

First Name _____ Last Name _____

Date of Birth _____ Gender _____

Facility Information

Facility Name _____

Street Address _____

City/Zip Code _____ Facility Phone Number _____

Contact Person Name _____ Phone _____

Insurance Information

Medicare Member ID _____ Social Security # _____

Plan Name _____ Member ID _____

Plan Name _____ Member ID _____

Plan Name _____ Member ID _____

Medical Information

Diet: _____

Allergies: _____

Diagnosis: _____

Pharmacy Information

Pharmacy Name _____

Street Address _____

City/Zip Code _____

Phone _____ Fax _____



CONFIDENTIALITY NOTICE: The contents of this form and any attachments are intended solely for the signee(s) and may contain confidential and/or privileged information and may be legally protected from disclosure. If you are not the intended recipient of this form or their agent, or if this form has been provided to you in error, please immediately alert the sender. If you are not the intended recipient, you are hereby notified that any use, dissemination, copying, or storage of this message or its attachments is strictly prohibited.

Primary Care Physician Information

Physician Name _____

Street Address _____

City/Zip Code _____

Phone _____ Fax _____

Other Physician Information (if applicable)

Physician Name _____

Street Address _____

City/Zip Code _____

Phone _____ Fax _____

Active Medication RX Name	RX Instructions	Quantity of Pills on Hand	Time / Hours of Administration



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To Whom It May Concern:

The following resident will change their pharmacy to LifeScript Pharmacy. This change will be effective on this DATE _____.

Former Pharmacy Information

New Pharmacy Information

Former Pharmacy Name:	LifeScript Pharmacy
Facility Name: Address: Tel: Fax:	39039 Paseo Padre Parkway Ste 201 Fremont, CA 94538 Tel: (510) 878-7562 Fax: (510) 878-7869
Street Address:	Date Effective: <hr/> (Date)
City: State:	
Zip:	

Name of Client(s) / Resident Name

Sign: Authorized Resident Representative

Date

Print: Authorized Resident Representative

The agreement is effective immediately upon signature. Failure to comply with the agreement is in direct violation of California Pharmacy Law Section 4001.1 and will result in a complaint filed with the California Board of Pharmacy in accordance with 4175(a).

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Credit Card Intake Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other: _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____ CVV: _____
Cardholder ZIP Code (from credit card billing address):	_____

I, _____, authorize Lifescript Pharmacy to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date



PH: (510) 878-7562

FAX (510) 878-789

39039 Paseo Padre Parkway St. 201, Fremont, CA 94538