# BELL APOTHECARY
# NEW PATIENT FORM

When you fill out this form and return to us by fax, or personal visit, we will contact your current pharmacy (or pharmacies) to transfer your prescriptions to Bell Apothecary. Please allow 24 hours for the transfer to be completed. We will call you when your prescriptions are ready to be filled. Our goal is to fill all of your medications at one month or three months supplies per your insurance (synchronizing). Our telephone number (610) 258-2311. The fax number (610) 252-0972. We also provide Durable Medical Equipment and Supplies. We install and repair Acorn Stair Glides. Golden Technology Electric Chairs . Repair Shop for medical equipment.

| | | | |
|---|---|---|---|
| NAME:<br><br>Last Name First Middle | | | |
| DATE OF BIRTH: | CELL PHONE NUMBER: | | |
| WORK TELEPHONE NUMBER:<br>( ) | HOME TELEPHONE NUMBER:<br>( ) | | |
| Family Member Phone Number<br>( ) | SOCIAL SECURITY NUMBER: | | |
| E-MAIL: | | | |
| HOME ADDRESS: | CITY: | STATE: | ZIP: |
| BUILDING NAME | | APT # | |

WOULD YOU LIKE EASY-OPEN TOPS ON PRESCRIPTION BOTTLES? ☐ Yes ☐ No

DO YOU HAVE ALLERGIES TO MEDICINE? ☐ Yes ☐ No
If yes, please list which medications.

_____

_____

DESCRIBE THE TYPE OF REACTION(S) YOU HAVE HAD. _____

_____

_____

| MEDICATIONS CURRENTLY TAKING | | | |
|---|---|---|---|
| **Prescription Number** | **Medication Name** | **Dose/Strength** | **Dosing Instructions** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Insurance Information: Please include any Secondary Insurances

| | |
|---|---|
| Plan Name | |
| RX Group Number | |
| RX BIn Number | |

RX PCN Number

| | |
|---|---|
| | |
| | |
| | |

METHOD OF PAYMENT

☐ Cash ☐ Check ☐ Visa/MasterCard ☐ Flex Spending Account ☐ Discover ☐

CREDIT CARD INFO: Card Number_____ Exp Date_____ CVV_____

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: ( ) _____

**BELL APOTHECARY**
**2045 FAIRVIEW AVE**
**EASTON,PA 18042**
**P-610-258-2311**
**F-610-252-0972**