CHATHAM CARES PHARMACY

APPLICATION FOR SERVICES

Name _____

Address_____ _

_____

Phone Number _____

Date of Birth _____

Social Security # _____

Female Male

Married Single Divorced Widowed

Ethnicity: Caucasian African-American Hispanic Other

INSURANCE:

Medicaid#_____ (If rejected we need copy of Medicaid letter)

Medicare#_____ VA _____

Other Insurance_____
(Name and policy number)

Notes:

_____

_____

Primary Care Doctor_____

Other Doctors: _____

FINANCES (Fill in all monthly income and assets) (indicate pay period- wk, month)

Salary/Wages source:_____	$_____	
Social Security:	$_____	-
SSI (Supplemental Security Income)	$_____	-
Pension/Retirement from:	$_____	-
Unemployment Compensation	$_____	-
Workers Compensation	$_____	-
Alimony/child support	$_____	-

TOTAL GROSS INCOME FOR HOUSEHOLD $ _____

Assets

Checking Acct	$_____		
Savings Account	$_____		
CD's	$_____		
IRA/retirement/annuity	$_____		
Other	$_____		
TOTAL: _____			

MEDICATIONS:

LIST ALL MEDICATIONS (prescriptions, over-the-counter, herbals, vitamins, etc. that you take)

Name of Medicine	Strength	How Often Taken?	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES to medicines (list each allergy and the reaction you had to that medicine)

1. _____
2. _____
3. _____
4. _____

********* I certify that I have NO health insurance including Medicaid, Medicare and VA. I also state that the information I have provided is true and complete to the best of my knowledge. I have read the information above and agree with it. I hereby give CCCP permission to verify this information.

Signed _____

Date _____