PATIENT ENROLLMENT FORM

***Type of Accident: (Circle) Slip\Fall / Workers' Comp / Auto Accident / Other_______________**

***Client Name:** ____
Last First Middle Gender

***Address:** ____
Street Apt # City State Zip

***Primary Phone Number:** ____________________ ***Alternate Phone Number:** _________________________

***Social Security #:** __________________________ ***Primary Language:** ____________________________

***Date of Birth:** ___________________________ ***Client Email Address:** ____________________________

***Description:** ____ ***Date of Injury:** ____________________
Brief Description of How Injury Occurred

***Treating Physician(s):** ____
Name Phone

____
Address City State Zip

***Law Firm:** ____
Firm Name Attorney Name Phone

____
Case Worker/Paralegal Name Phone

Carrier: ____
Name Phone

____
Address City State Zip

***Claim Number:** ____

***Adjuster Name:** __________________________________ Phone: _______________ Fax: _____________

<u>**IF WORKERS' COMPENSATION:</u>

***Employer:** ____
Name Phone

____
Address City State Zip

Medications being taken (with RX number, pharmacy, dosages and due date, if applicable):

____
____
____
____
____
____
____

Allergies: ____

Notes: ____
____
____
____
____
____
____

***Please Include Copy of Driver's License.**

Staff Initials____

<u>Please submit completed forms via email to:</u>

ENROLLMENT@OURPHARMACYNETWORK.COM

<u>OR</u>

<u>Via fax to: 844-222-3947</u>