DRIVE-IN DRUG STORE

Rx TRANSFER FORM

Patient Name:

Last: First: Middle Initial:

Physical Address:

City: State: Zip:

Date of Birth: Phone: Male / Female

Social Security Number:

Would you like us to text you when your medication is ready for pick up? (Circle) Y or N

Cell # Cellular provider:

O Yes, I would like medication dispensed in child resistant container

O No, I would not like medication dispensed in child resistant container

Prescription Insurance: Yes / No Cardholder Name:

PHARMACY NAME FROM WHICH RX'S ARE TO BE TRANSFERRED:

Pharmacy Phone:

Rx#_____ Name of medication_____ Dosage _____

Rx#_____ Name of medication_____ Dosage _____

Rx#_____ Name of medication_____ Dosage _____

Rx#_____ Name of medication_____ Dosage _____