PROACT®
PHARMACY SERVICES
Pharmacy Benefit Dimensions®

Patient Profile Form

Insured Family Member

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Spouse

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Dependent

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Prescriptions Enclosed (New/Refills)

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Total Prescriptions Enclosed: **New:**_____ **Refills:**_____

Please Contact us at 1-888-425-3301 to arrange a form of payment to avoid delays in shipping your prescription orders.

Completed Forms can be returned to: **ProAct Pharmacy Services; 1226 US Hwy 11; Gouverneur, NY 13642**

Receipt of Privacy Practices

I acknowledge the receipt of the ProAct Pharmacy Services Notice of Privacy Practices

_____ _____ _____

Signature of Insured Family Member Printed Name of Insured Date