Rock Creek Shopping Center: **8309 Grubb Rd, Silver Spring, MD 20910**
Ph: **301-200-8472** Fax: **301-710-5319**
Email: **cmpmeds@gmail.com**
Hours: Sun: 10a - 3p **Mon - Fri:** 9a - 8p **Sat:** 9a - 5p

NEW PATIENT INFO & PRESCRIPTION TRANSFER FORM

Last Name **First Name** **Middle Name**

Apt / Suite Number **Home Number** **Mobile Number**

☐ **M** ☐ **F** ____/____/____ _____ @yahoo.com @gmail.com @_____

Sex **Date of Birth** **Email**

List All Allergies:

_____

PRESCRIPTION TRANSFER FORM *(PHARMACY CARDS HAVE A "BIN#")*			
INSURANCE 1 ***(Primary)***		**IF ANY: INSURANCE 2** ***(Secondary)***	
RX BIN	*ID #*	*RX BIN*	*ID #*
PCN	*RX GROUP*	*PCN*	*RX GROUP*

MEDICATION RECORD

If you are ONLY using one (1) pharmacy for all your prescriptions, only fill PART A; if not, please fill PART B.

PART A

Pharmacy Name: _____ **Phone Number:** _____

PART B

Prescription Number	Medication Name & Strength	Pharmacy Name & Number	Prescription Number	Medication Name & Strength	Pharmacy Name & Number

☐ I authorize Corner Market & Pharmacy to contact the pharmacy I have listed to transfer my prescriptions to Corner Market & Pharmacy.

Signature: _____ **Date:** _____

Complete and return this form via fax, email or mail:

Fax: **301-710-5319**
Email: **cmpmeds@gmail.com**
Mail: **8309 Grubb Rd, Silver Spring, MD 20910**