Welcome

LAMBERT'S PHARMACY PH : (856-428-5888) Email : MEDSCARERX@gmail.com Thank you for choosing our Pharmacy team for your health care needs! We will strive to provide you with the best possible Pharmaceutical care. Please fill this form completely for a faster service.

Patient Information (CONFIDENTIAL):

Patient Name (First)_____ (Last) _____

Birth date_____ Food/Medication Allergies _____

Address _____

Phone (Ho #)_____(Cell # &Carrier)_____

Email_____Emergency Contact _____(Ph)_____

Insurance Information:

Rx Insurance Company Name_____ID# _____Group_____

Rx BIN : _____ PCN _____

Medicare/SS# _____

Current Pharmacy _____ Ph#_____

Primary Doctor Name _____ Ph# _____

List of Current Medications/Health condition(s):

1)_____2)_____
3)_____4)_____
5)_____6)_____

Please check if willing to join **Auto/Courtesy Refill(s) Program** _____(Yes)_____(No)

Vaccination History:

Flu_____Pneumonia_____Shingles_____RSV_____