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SELF-PAY & PRIMARY INSURANCE INFORMATION

(Please complete this form – if you have insurance, we need your information in order to speak to pharmacies about your medication. If you do not have insurance, still complete the form since it references Self-Pay)

Patient Name: _____ DOB: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Employer: _____

No insurance: **Self pay** _____

Insurance: _____

Insured S.S. # _____

Relationship to Patient: Self Spouse Child Other _____

_____

Signature of Patient or Parent/ Guardian Date