CMMC Pharmacy
at Central Maine Medical Center

12 High Street
Lewiston, ME 04240
(207) 795-7177

Patient Name

Last First MI

Mailing address City State Zip

Phone E-mail Address

Date of Birth (Month/Day/Year)

Sex (circle one): **M** **F**

1) Would you like us to dispense your medications in child resistant packaging?

☐ Yes
☐ No

2) Would you like to be notified of a completed prescription by text message or email?

Email	*Text*
☐ Yes	☐ Yes
☐ No	☐ No

Phone Carrier:_____

3) Would you like to sign up for Autofill?

☐ Yes
☐ No

4) Do you have prescription Insurance?

☐ Yes. If yes please provide a copy of front/back of card to pharmacy via fax.
☐ No

5) Would you like your prescription mailed to the address listed above?

☐ Yes. If yes, please complete Credit Card Authorization form and fax to pharmacy.
☐ No

Pharmacist Comments

This information is requested by CMMC Pharmacy so we can provide appropriate pharmacy services to you. Since health information may periodically change, please notify the CMMC Pharmacy of any changes in medications (prescription, non-prescription, and herbal), allergies, drug reactions or health conditions. Please return this form to CMMC Pharmacy or fax to 207-795-7552. We thank you for allowing us to serve your medication needs!

_____

Signature Date

Fax to Pharmacy at: 207-795 – 7552