

REGISTRATION / PRESCRIPTION ORDER FORM, cont.

DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Be sure to complete Member Information section

Dependent Name: _____
First Middle Initial Last

Address: _____
Street or P.O. Box Suite or Apt # City State Zip

() _____ () _____
Daytime Phone Evening Phone

Date of Birth: / / Female: Male:
MM DD YYYY

Relationship to Cardholder: _____

Doctor's Name: _____ Dr.'s Phone: _____
First Last

Patient requests easy-off caps
 Patient requests Spanish language on labels

Allergies:
 32-Codeine 70-Penicillin 87-Sulfa 93-Tetracycline No known allergies
 Other (list): _____

Health Conditions:
 200-Diabetes 300-Hypertension 400-Heart Disease 500-Glaucoma
 600-Stomach Disorders 700-Thyroid Disease 800-Arthritis No known health conditions
 Other (list): _____

CREDIT CARD INFORMATION

Credit Card Number: _____
(Please circle: Visa, MasterCard, Discover)

Credit Card Number: _____
(American Express)

Name as it appears on card: _____
First Middle Initial Last

Expiration Date: / / Signature: _____
MM DD YYYY

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Samaritan Pharmacy Services will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center at (541) 768-5225 to advise.

Simply mail your original prescription and this form along with your credit card information or check made payable to:
 Samaritan Pharmacy Services, 3521 NW Samaritan Drive, Suite 202, Corvallis OR 97330
 Customer Care Center: (541) 768-5225, toll free 1-866-374-7245
 Refills by Phone: (541) 768-5230