PEACHCARE DRUGS & MEDICAL SUPPLY
550 FRANKLIN ROAD SUITE C
MARIETTA, GA 30067
678 581-1223
678 581-2356 FAX
admin@peachcaredrugs.com

PHARMACY SERVICES AGREEMENT

Resident Name_____

Community Name_____

Address_____City_____State____Zip Code_____

Phone_____Date of Birth_____Social Security#_____

Physician_____Phone_____

Medical Conditions_____

Drug Allergies_____

Prescription Insurance Company (if applicable)_____

ID Number_____ Group Number_____

Phone Number_(____)_____

Responsible Billing Party_____

Relationship to Resident_____

Address_____

City_____State_____Zip Code_____

Phone Number (Daytime)_____(Evening)_____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION:
I authorize any health care professional, or any of their designees, any and all records of information pertaining to medical history or services rendered to me for any administrative purpose, including evaluation of an application or a claim, and for any analytical purposes. I authorize the use of my Social Security Number for purposes of identification.

Signature_____Date_____