CHET JOHNSON DRUG
Amery, Wisconsin

Patient Information

Name (First)_____(M.I.)_____(Last)_____

Previous last names (if any, such as maiden name)_____

Birth Gender (or Gender on file with insurance company): ☐ Male ☐ Female

Address (Street)_____ (Apt # or PO Box)_____

(City)_____ (State)_____ (ZIP)_____

Birth Date _____ Current Age _____ Last 4 Digits of SSN __ - __ - __ - __

We can use your cell # or email to send you text messages about your prescription order IF you would like us to. For instance, we can text you that your order is ready, or that we need your insurance card updated. Note: Due to privacy restrictions, **notification is available for patients age 18 and older**.
If you are age 18 and older, do we have your permission to contact you by cell phone or email?

Circle answer: Yes <or> No If YES, circle preferred: Text message <or> email

Cell Phone _____-_____-_____

Other Phone _____-_____-_____ Home – Work (circle one)

Email (provide if notification method) _____

Drug Allergies - please give us as much detail as you can recall about the nature of the allergy:

Drug_____ Problem _____

Drug_____ Problem _____

Drug_____ Problem _____

Other medications you are on that are not filled at this pharmacy:

_____

_____

Chronic medical conditions: _____

_____

Do you have difficulty opening child-resistant medication bottles?

☐ Yes, I would like Easy Open caps. (I understand that these are not child-resistant.)
☐ No, I prefer standard child-resistant caps.

I have read and agree to the statements above:

(Signature) _____ (Date)_____

If you are completing this for another individual, please give us your name and relationship to the patient:

Name_____ Relationship _____

Please include your prescription insurance card and driver's license with this form. (Clerk Initials _____)

Chet Johnson Drugs, Inc. 204 Keller Avenue North P.O. Box 17 Amery, Wisconsin 54001
PHONE 715-268-8121 TOLL FREE 888-539-9210 FAX 715-268-4733

PRESCRIPTION TRANSFER REQUEST:

Today's Date Completed by:

Pharmacy

Address

Pharmacy Phone

Patient DOB

Address Phone

City, State, Zip

RX Information (Rx #, Drug Name, etc): Is there anything that is needing to be filled NOW ?

Special services (Sync, compliance packaging, delivery or mail):