Center Drug

Hopkins Center Drug
913 Hopkins Center
Hopkins, MN 55343
P 952-938-2719 F 952-938-1147

ENROLLMENT FORM

Facility Name:_____ Apt Number_____

Patient Information:

Last Name:_____ First Name:_____

Date of Birth:_____ Gender: Select a gender

Allergies:_____

Insurance Information:

Insurance Company:_____

RX BIN:_____ RX ID #:_____

RX PCN:_____ Relationship:_____

RX GROUP:_____ (Send along a photo copy of the insurance card)

NAME & ADDRESS TO SEND BILLING INFORMATION TO:

Last Name:_____ First Name:_____

Relationship:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

EMERGENCY CONTACT:

Last Name:_____ First Name:_____

Relationship:_____ Phone:_____

CREDIT CARD INFORMATION:
(If you want us to put monthly statement charges on card)

Charge Monthly ☐ Charge only if authorized ☐

Name on Card:_____ CVV:

Card Number:_____ Exp. Date_____

Hopkins Center Drug will provide medications to the patient listed only after completion of this form. By signing below, you are consenting to help in any way possible to keep the information regarding the patient's account and insurance information current. Statements on accounts with a balance will be mailed near the first of every month and are payable by the 25th of the month.

Signature:_____ Date:_____