We make it easy to switch

It's easy to get started!

We have a licensed specialist contact your doctors, verify your medications and doses and transfer all your prescriptions.

All you need to do is fill out this form to the best of your ability and we'll do the rest.

Any questions? Call us, we're here to help!

You are moments away from a better, simpler pharmacy.

www.personalrx.com
(201) 430-7300

Personal Rx®

Patient Information

PATIENT

First Name	
Middle Name	
Last Name	
Date of Birth	
Gender	
Home Address (Street, City, State, Zip)	
Phone Number(s)	
Email Address	
List all allergies and severity (both food & medication)	

PRIMARY CONTACT (guardian/caregiver)

Same as Patient ☐

First Name	
Relationship to Patient	
Phone Number	
Email Address	

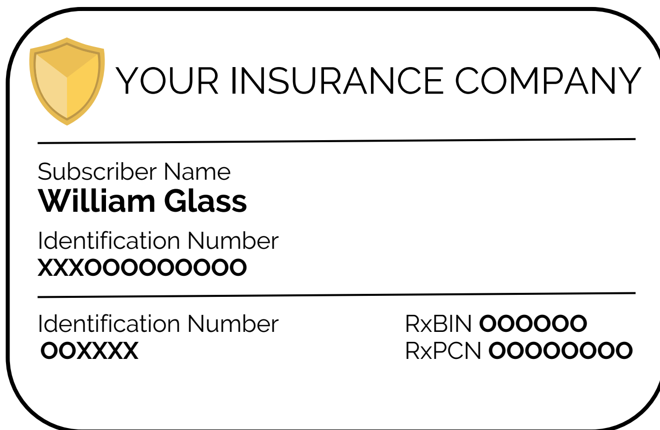
Name of Patient (Please Print):______________________________

Personal Rx®
Insurance

Please provide information and a copy of the front and back of each medication prescription insurance plan cards.

Subscriber	
ID #	
Group #	
RX BIN	
RX PCN	

Front of Card



Back of Card

Name of Patient (Please Print): ______________________________

Personal Rx®

Physician & Medication List

Liquid medications, inhalers, PRN medications and any others specified for separate packaging will be included with delivery, separate from the dose packaged medications. OTC items, including vitamins and dietary supplements, can be packaged along with prescription medications according to designated time of dose.

If you do not have all medication information, please simply fill in prescriber information and PersonalRX will contact them to confirm.

Physician Name & Phone #	**Medication Name** (Include OTC, vitamins & supplements)	**Dose** (ie: 3 mg)	**Directions** (# taken at each time of day)
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:
			Morning[ ] Afternoon [ ] Evening [ ] Bedtime [ ] Other directions:

Name of Patient (Please Print):____

Personal Rx®

Credit Card Authorization

This form must be completed for all credit cards submitted.
Fax: (201) 334-0700 or email to support@personalrx.com

Card Type (Visa, MasterCard, American Express, Discover)	
Check if HSA or FSA Card?	HSA [ ] FSA [ ]
Billing Address Check if same as shipping address [ ]	
Name on Card	
Card Number	
Expiration Date	
Security Code	

I acknowledge and assume responsibility and grant authorization for DGN Pharmacy, Inc./ PersonalRX/ GroupRX "Pharmacy" to charge the above credit card for the cost of any medication not covered by patient's insurance company, as well as any co-insurance and deductibles and charges for requested OTC/Sundries or non-standard delivery services. I authorize the pharmacy to contact my insurance company for insurance verification, billing, and collections for my medications. As per the HIPPA agreement (available online at www.PersonalRX.com) all personal information received will be solely maintained for the purposes of dispensing prescriptions and insurance collection and payment. I understand that I am responsible for the costs of all medication changes received after a prescription has been filled or packaged.

“PATIENT RIGHT TO COUNSEL” NOTIFICATION
We invite you to use our toll-free number to contact a PersonalRX pharmacist regarding any questions you may have about your prescription medication. For urgent needs, you may reach a PersonalRX pharmacist at any time.

Name of Patient (Please Print):____

Signature of Guarantor/Cardholder:____

Date:__________________________