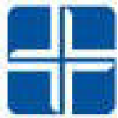

UnityPoint Health

Patient Information

First Name: ______________ Middle Initial: ____ Last Name:__________________ Date of Birth: ___/__/__

Employee Name (if patient is a family member): ________________________ Relationship: ______________

Phone Number (Mobile/Home): _____________________ Phone Number (Work): ______________________

Email Address: ____

Home Address: ____

Work Location: ____

Allergies (include medication name & reaction): ____

Billing Information

Pharmacy Insurance ID Number: ______________________________ Group Number:_________________

BIN Number: ________________________ PCN Number: _________________

Copay Payment:

____Charge to the credit card, FSA, or HSA (Pharmacy will contact you for card information)

Release

I give permission to UnityPoint Health Moline Trinity Hospital Outpatient Pharmacy employees to:

- Update my preferred pharmacy in the electronic health record.
- Contact my provider for additional refills if needed.
- Bill my insurance plan and selected payment method for any copays.

Patient Signature: ____ Date: _____/_____/____

*Please complete the Prescription Transfer Form on the back

Prescription Transfer Form

Patient Name:____ DOB:____________________

Current Pharmacy Name: ___________________ Location: ________________ Phone Number: ______________

Primary Care Physician: _____________________Location: _________________ Phone Number: ______________

Medication Name	Strength	Directions	Quantity Per Fill	Prescriber Name	Rx Number	Date Next Fill is Needed

Please return this form to the Moline Trinity Hospital Outpatient Pharmacy by one of the following methods:

In person or by mail: Trinity Hospital Outpatient Pharmacy, 500 John Deere Rd, Moline, IL 61265
located through Main Entrance near Registration

Email: billy.mccallister@unitypoint.org

Fax: 309-779-5018