P.O. Box 1159
Wilmington, DE 19899
Toll Free: 877.658.9196
302.658.9196
Fax: 302.658.8495

RADIUS RX DIRECT

www.RadiusRxDirect.com

NEW PATIENT ENROLLMENT FORM

ALL INFORMATION WILL BE CONFIDENTIAL AS REQUIRED BY THE HIPPA GUIDELINES

PERSONAL INFORMATION

First Name: _____ MI: ____ Last Name: _____ Birth Date (MM/DD/YY): _____/_____/_____

SS#: _____ Gender: M ☐ F ☐ Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Practice/ Facility/ Clinic: _____ Deliver to: ☐ Home ☐ Clinic

Due to cultural background and/or religious beliefs, is there anything Radius Rx Direct should know that would help us better care for you?

_____

_____

_____

DRUG ALLERGIES (please select all that apply)

☐ No known allergies ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Tetracycline Other_____

HEALTH CONDITIONS (Please select all that apply)

☐ None Known ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Glaucoma ☐ Heart Disease ☐ Hypertension ☐ Pregnancy ☐ Thyroid Disease

☐ Other _____

INSURANCE INFORMATION

☐ Medicare ☐ Traditional Medicaid ☐ Ameri Health ☐ Highmark ☐ Other _____

ID # (located on Insurance Card): _____ Group # (located on Insurance Card):_____ Bin # (if applicable): _____

Policy Holder's Name: _____ Employer: _____ Relationship to Insured: ☐ Subscriber ☐ Spouse ☐ Dependent

RADIUS RX DIRECT INC. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the notice of privacy practices for Radius Rx Direct Inc. ☐ Yes ☐ No

TO THE BEST OF MY KNOWLEDGE ALL THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Name of Patient (Print): _____ Signature: _____ Date (MM/DD/YY): _____

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form) _____

FAX OR MAIL SIGNED ENROLLMENT:
FAX: 302.658.8495
RADIUS RX DIRECT –P.O. BOX 1159
WILMINTON, DE 19899