Lehigh Valley Health Network
Your health deserves a partner.

PATIENT ENROLLMENT FORM

Health Spectrum Pharmacy Services

Please indicate which LVHN campus you are employed at:

Cedar Crest	Pocono	Other (ExpressCARE, offsite LVPG office, etc):
Muhlenberg	Hazleton	
17th Street	Schuylkill	_____

Section 1: Patient Information & Allergies

If additional space is needed, please continue on a second form.

Patient 1 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female ☒ Cardholder

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 2 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female Spouse Dependent

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 3 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female Dependent

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 4 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female Dependent

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 5 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female Dependent

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Patient 6 _____ First Name _____ Last Name _____ Date of Birth (mm/dd/yyyy) Male Female Dependent

No Known Allergies _____ List any drug allergies and any reaction you had. Include over-the-counter medications.

Please complete the "Delivery & Contact Information" and "Payment Information" sections located on page 2.

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Section 2: Delivery & Contact Information

Primary Address: (Patient 1's name will be utilized),

Street Address	Apartment/Ste.	City	PA State	Zip Code

Cell / Home / Work — Daytime Phone Number

Cell / Home / Work — Evening Phone Number

Email Address

Secondary Address: (college, 2nd home, caretaker, etc…) **Dates:** **to**

Street Address	Apartment/Ste.	City	PA State	Zip Code

Cell / Home / Work — Daytime Phone Number

Cell / Home / Work — Evening Phone Number

List Patient(s) At This Address When In Use

Tertiary Address: (college, 2nd home, caretaker, etc…) **Dates:** **to**

Street Address	Apartment/Ste.	City	PA State	Zip Code

Cell / Home / Work — Daytime Phone Number

Cell / Home / Work — Evening Phone Number

List Patient(s) At This Address When In Use

Section 3: Payment Information

This payment information will apply to all patients listed in Section 1

Please provide your regular credit card info and, if enrolled, your healthcare flexible spending (FSA) credit card information

☐ **Check here to have a Health Spectrum staff member contact you for your credit card information.**

Credit Card Number	Expiration Date	Name on Card	Visa / MasterCard / Amex / Discover

FSA Card Number (if applicable)	Expiration Date	Name on Card	Visa / MasterCard / ☒ FSA

By signing, I certify that I am authorizing Health Spectrum Pharmacy Services to charge the credit card(s) listed above and any subsequent cards that are provided for the cost of the prescriptions and any shipping fees that are incurred by utilizing this convenience shipping services. I also certify that I have received, read and understand all of the provisions and guidelines contained on this form and on the accompanying Convenience Shipping Information form. Prescriptions will not ship unless payment is made and are non-returnable.

Name (Please Print)	Signature	Date

Fax completed form to Health Spectrum - Cedar Crest at (610) 402-8800.