General Enrollment Form

Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: ______

Address: ______

City: ______ State: ______ Zip: ______

Primary Phone: ______ DOB: ______

Alternate Phone: ______ Gender: ☐ Male ☐ Female

Email: ______

Last Four of SS #: ______ Primary Language: ______

Height: ______ Weight: ______

PRESCRIBER INFORMATION

Prescriber's Name: ______

State License #: ______ NPI #: ______

DEA #: ______

Group or Hospital: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Fax: ______

Contact Person: ______ Phone: ______

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date: ______ **Ship to**: ☐ **Patient** ☐ **Physician** ☐ **Other:** ______

Diagnosis: ______ **ICD-10 Code:** ______ **Date of Diagnosis:** ______

Prior Medications Used: ______

Current Medications: ______

Allergies: **Is the patient new to therapy?** ☐ **Yes** ☐ **No**

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐				
☐				
☐				

X ______ X ______

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

PHYSICIAN SIGNATURE REQUIRED

Date Needed: ______ Medication Start Date: ______

The information included in this FAX is intended for the sole use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute this information. If you have received this FAX in error, please contact the sender and destroy the entire document. 15561876 (11/16)