

**Teamsters Rx Pharmacy**  
*Teamsters Owned and Operated*  
*Non-Profit Mail-order Pharmacy*  
**PO Box 5242**  
**Manchester, NH 03108**  
**Pharmacy: 1.866.888.0104**  
**Fax: 1.603.413.6410**

**Patient Profile**

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**Please complete and mail or fax form**

Today's Date: \_\_\_\_\_ ID#: \_\_\_\_\_  
(if available)

**Rx Delivery** Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

EMAIL Address: \_\_\_\_\_

<b>Member's Name:</b> _____	<b>Dependent's Name:</b> _____
Birth Date: ____ / ____ / _____ Sex: _____	Birth Date: ____ / ____ / _____ Sex: _____
Home Phone: (____) _____	Home Phone: (____) _____
Cell Phone: (____) _____	Cell Phone: (____) _____
Work Phone: (____) _____	Work Phone: (____) _____
Person Code: ____ ____ (if available)	Person Code: ____ ____ (if available)

**Please check all that Apply for each dependent:**

<u>Health Conditions</u>	<u>Drug Allergies</u>	<u>Health Conditions</u>	<u>Drug Allergies</u>
ADD/ADHD	None	ADD/ADHD	None
Asthma	Aspirin	Asthma	Aspirin
Diabetes	Codeine	Diabetes	Codeine
Depression	Erythromycin	Depression	Erythromycin
High Cholesterol	Iodine	High Cholesterol	Iodine
High Blood Pressure	Penicillin	High Blood Pressure	Penicillin
Thyroid	Sulfa drug	Thyroid	Sulfa drug

Other Health Conditions and /or other drug allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Health Conditions and /or other drug allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Prescriptions cannot be faxed by the member\***  
**(by Law faxed Rx must originate from M.D.'s office)**

**Page 2 of Patient Profile**

Dependant Name: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_  
Person Code: \_\_\_\_ (if available)

Dependent Name: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_  
Person Code: \_\_\_\_ (if available)

Rx Mailing Address if Different from Member's

Rx Mailing Address if Different from Member's

\_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip

**Please check all that Apply for each dependent:**

<u>Health Conditions</u>	<u>Drug Allergies</u>
ADD/ADHD	None
Asthma	Aspirin
Diabetes	Codeine
Depression	Erythromycin
High Cholesterol	Iodine
High Blood Pressure	Penicillin
Thyroid	Sulfa drug

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Other Health Conditions and /or other drug allergies

Other Health Conditions and /or other drug allergies

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\_\_\_\_\_  
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Dependent Name: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_  
Person Code: \_\_\_\_ (if available)

Dependent Name: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_  
Person Code: \_\_\_\_ (if available)

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Rx Mailing Address if Different from Member's

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Street  
\_\_\_\_\_  
City State Zip

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City State Zip

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Thyroid	Sulfa drug

Other Health Conditions and /or other drug allergies

Other Health Conditions and /or other drug allergies

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