Whole Health Pharmacy
1040 South 70th Street
Milwaukee, WI 53214

Phone: 414-476-9675
Fax: 414-615-0626

Enrollment Form

Client Information		**Billing Address**	**Same as Client Address** ☐
Client Name (*First, Last*):		Name:	
Address:		Address:	
City/State/Zip:		City, State, Zip:	
Phone:			
Date of Birth:		Social Security #:	

Insurance Information *(attach copy of both sides of insurance card)*

Forward Health #:		Gender:	☐ FEMALE ☐ MALE
Other Insurance Name:			
ID:		Group/Policy:	

Medical Information		**LEASE ATTACH CURRENT MEDICATION LIST or Complete List on the Back Pag**	
Primary Care Provider:		Clinic:	
Phone:		Address:	
Fax:		City/State/Zip:	
Psychiatrist:		Clinic:	
Phone:		Address:	
Fax:		City/State/Zip:	
Other Provider:		Clinic:	
Phone:		Address:	
Fax:		City/State/Zip:	

Drug Allergies

Referral Source

Name:		Organization:	
Phone:		Address:	
Fax:		City/State/Zip:	
Date of Referral:			

Pharmacy Packaging		**Prescription Delivery?**	**Prescriptions Tranferred?**	**Pharmacy Information**
Medicine On Time	☐	☐ YES	☐ YES	Pharmacy Name:
Bottles	☐	☐ NO	☐ NO	Address:
				Phone:
Start Date:			Prescription (Rx) #'s:	

Other Information:

Pharmacy Date Received: **Pharmacist:**

Current Medication & Supplement List

Prescribed Medication	Vitamins & Supplements	Herbal or Dietary Supplements

Questions or Concerns for the Pharmacy Staff