Patient Profiles & Prescription Order Form

Wal-Mart Pharmacy Mail Services
PO Box 115112
Carrollton, TX 75011-5112
1-800-2-REFILL
(1-800-273-3455)

Christian Association of PrimeTimers	CAP Membership Number		
CAP Member Name	Date of Birth ☐ Male ☐ Female		
Street Address	City	State	Zip
Home Telephone	Daytime Telephone & Extension		

PATIENT INFORMATION

Please complete the section below **for all eligible family members**. This information will be used to check for potential prescription drug interactions.

Member Name ______________________ Date of Birth ______________ ☐ Male ☐ Female
Drug Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Sulfa ☐ Aspirin ☐ Other ______________
Health Conditions ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure ☐ Other ______________

Spouse Name ______________________ Date of Birth ______________ ☐ Male ☐ Female
Drug Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Sulfa ☐ Aspirin ☐ Other ______________
Health Conditions ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure ☐ Other ______________

Dependent Name ______________________ Date of Birth ______________ ☐ Male ☐ Female
Drug Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Sulfa ☐ Aspirin ☐ Other ______________
Health Conditions ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure ☐ Other ______________

Dependent Name ______________________ Date of Birth ______________ ☐ Male ☐ Female
Drug Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Sulfa ☐ Aspirin ☐ Other ______________
Health Conditions ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure ☐ Other ______________

Dependent Name ______________________ Date of Birth ______________ ☐ Male ☐ Female
Drug Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Sulfa ☐ Aspirin ☐ Other ______________
Health Conditions ☐ Thyroid ☐ Diabetes ☐ Glaucoma ☐ Heart Conditions ☐ High Blood Pressure ☐ Other ______________

Please Read and Sign: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, and I AUTHORIZE WAL-MART MAIL SERVICE PHARMACY TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS.

Signature: ______________________________ Date: / /

Rev: 06/03