Family Medicine Center Pharmacy Ltd
Tel: (242)-702-9300
Fax: (242)-327-1462
pharmacy@familymedicinecenter.org

Patient Information Form

Name: ______________________________________ Date of Birth: ______________ (D/M/YY)

Address: ____

Tel HM: (242) ______________Tel Cell: (242) ______________ Tel WK: (242) _______________

Payment Method (Tick as appropriate)

☐ National Insurance Prescription Card: **Must provide ACE Card**

☐ Medical Insurance:

Name:____

Policy Number _________________________ ID # ______________________________

☐ Self and Medical Insurance Co-payment:

Credit or ATM Card #: ____

Name: ____

Type of Card: ____

Card Exp: _________________ (M/YY) Card Code: ___________________________

I hereby authorize Family Medicine Center Pharmacy Ltd (FMC Pharmacy) to prepare medications and medical supplies for shipment to Door2DoorEleuthera, Rock Sound, Eleuthera. FMC Pharmacy will not be held responsible for the delivery of medications or medical supplies.

Door2Door Eleuthera will charge a Fee of $10 for delivery of medications and medical supplies.

Patient Signature: _____________________________ Date: ____________________ (D/M/YY)