*RXDN*
*Remote Xpress Distribution Network*
P.O. BOX 137 Bristol, PA 19007
Tel: 1-800-800-8769 Fax: 215-785-2923 www.rxdn.com

# Pharmacy Member Profile Form

***This form is for new members to establish initial data in our system. Please complete this form and return to us with your prescriptions.***

- **Primary card holder Profile:**

Last Name: ________________________ M.I.: ______ First Name: ________________________

Social Security#: ________________ Date of Birth: __________________ Sex: M_____ F_____

E-mail Address: ________________________________ Safety cap required: Yes_______ No_______

Delivery Address: ____________________________________________________________

Billing Address: ______________________________________________________________

Home Phone#: ______________ Work Phone#: _________________ Cell Phone#: ______________

Prescription plan: _____________________ Group #: ________________ ID#:________________

Primary Doctor: _______________________________ Phone#: _____________________

Drug allergies: _________________________________________________________________

- **Eligible family members' profiles:**

Name: ________________________________ D.O.B: _______________ Sex: M_____ F____

Drug Allergies: ___________________________ Relationship to card holder: ___________

Name: ________________________________ D.O.B: _______________ Sex: M_____ F____

Drug Allergies: ___________________________ Relationship to card holder: ___________

Name: ________________________________ D.O.B: _______________ Sex: M_____ F____

Drug Allergies: ___________________________ Relationship to card holder: ___________

Please use the back of this form for additional family members.

- **Payment options:** *Please indicate one of the following options*
  Pay by checks- please write prescription# on your check.
  Pay by credit card- VISA, MASTER, AMEX, & DISCOVER. We do not accept debit cards.

  Type of credit card: ________ Credit card#: ______________________________ Exp date: _________

  Security#________________ Authorized Signature: ___________________________________

**I HEREBY CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND I HAVE READ THE NOTICE OF PRIVACY PRACTICES. I AUTHORIZE RELEASE OF ALL INFORMATION TO RXDN.**

Card holder's Signature: ____________________________________ Date: __________________