

MYRXMANAGER MEMBER APPLICATION

APPLICANT INFORMATION

Name:		
Date of birth:	4 Digit Pin #:	Phone:
Current address:		Cell Phone:
City:	State:	ZIP Code:
Email:		

PHYSICIAN INFORMATION

Current Primary Care Physician:		
Address:		Phone:
City:	State:	Fax:
Email:		ZIP Code:
List all prescriptions you are taking that were prescribed by this doctor <i>(optional)</i> :		

(optional):

SPECIALIST: <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dermatologist <input type="checkbox"/> Dentist <input type="checkbox"/> Ophthalmologist (eye) <input type="checkbox"/> Cardiologist <input type="checkbox"/> Oncologist (cancer) <input type="checkbox"/> Endocrinologist (diabetes) <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other _____		
Address:		Phone:
City:	State:	Fax:
Email:		ZIP Code:

List all prescriptions you are taking that were prescribed by this doctor <i>(optional)</i> :		

(optional):

SPECIALIST: <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dermatologist <input type="checkbox"/> Dentist <input type="checkbox"/> Ophthalmologist (eye) <input type="checkbox"/> Cardiologist <input type="checkbox"/> Oncologist (cancer) <input type="checkbox"/> Endocrinologist (diabetes) <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other _____		
Address:		Phone:
City:	State:	Fax:
Email:		ZIP Code:

List all prescriptions you are taking that were prescribed by this doctor <i>(optional)</i> :		

Primary Pharmacy:		
Address:		Phone:
City:	State:	Fax:
Contact your Pharmacy for a list of prescriptions you are taking		ZIP Code:

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List any over the counter (OTC) medicines you currently take: (i.e. Aspirin, nasal sprays, etc.)

List Drug Allergies:

Secondary Pharmacy:

Address:		Phone:
City:	State:	Fax:
Contact your Pharmacy for a list of prescriptions you are taking		ZIP Code:

List any over the counter (OTC) vitamins or herbs you currently take: (i.e. vitamin E, C, iron pills, B12, etc.)

EMERGENCY CONTACT

Name of a relative or emergency contact person:

Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

CHILDREN IF MEMBERSHIP PRIVILEGES DESIRED

Name	Name
Name	Name

PAYMENT INFORMATION

Annual Fee: \$30 Seniors 55 years or older \$25 Children under 18 years or college students \$20

(optional): (Please add \$10 for an electronic Internet secured account and provide 4 digit pin number)

Credit Card Visa Master Card American Express Debit/Check Card Check (enclosed)

Name (as it appears on your card):

Card Number:	Expiration Date:	
(For CIC use only) Verification number:		
Billing Address (as it appears on your card) if different from the member address above		
Address:	Apt. #	
City:	State:	Zip:

SIGNATURE

I authorize Creative I C to act as my Rx manager for the purpose of obtaining, maintaining, monitoring and compiling confidential prescription medication. Electronic storage of this information in a password secured web based format will be provided as an optional service. I understand that no medical advice or consultation will be extended and this service is for tracking purposes only. The information provided on this form is accurate to the best of my knowledge. The applicant agrees to provide a print out of his/her current medications from the pharmacy and notify CIC when your medications change. CIC will issue a prescription card once a month upon receipt of a written change in the prescriptions displayed on the card when there is a change in information from the prior months prescription card. Four cards will be mailed or emailed to the member.

Signature of applicant:	Date:
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Mail, fax or e-mail application to:
 (804) 674-8332 Fax (804) 674-8443 Office

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 E-mail: myrxmanager@creativeic.com