



General Enrollment Form

Phone: 855-425-4085

Fax: 855-425-4096

ardonhealth.com

| | | | |
|---------------------|--|------------------------|-------------------------------------|
| PATIENT INFORMATION | Patient Name: _____ | PRESCRIBER INFORMATION | Prescriber's Name: _____ |
| | Address: _____ | | State License #: _____ NPI #: _____ |
| | City: _____ State: _____ Zip: _____ | | DEA #: _____ |
| | Primary Phone: _____ DOB: _____ | | Group or Hospital: _____ |
| | Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Address: _____ |
| | Email: _____ | | City: _____ State: _____ Zip: _____ |
| | Primary Language: _____ | | Phone: _____ Fax: _____ |
| | Height: _____ Weight: _____ | | Contact Person: _____ Phone: _____ |

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

| | |
|----------|--|
| CLINICAL | Need By Date: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____ |
| | Diagnosis: _____ ICD-10 Code: _____ Date of Diagnosis: _____ |
| | Prior Medications Used: _____ |
| | Current Medications: _____ |
| | Allergies: _____ Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILL |
|--------------------------|---|---------------|--|----------|--------|
| PRESCRIPTION INFORMATION | <input type="checkbox"/> | | | | |
| | <input type="checkbox"/> | | | | |
| | <input type="checkbox"/> | | | | |
| | <input checked="" type="checkbox"/> PRODUCT SUBSTITUTION PERMITTED _____ (Date) | | <input checked="" type="checkbox"/> DISPENSE AS WRITTEN _____ (Date) | | |

PHYSICIAN SIGNATURE REQUIRED

Date Needed: _____ Medication Start Date: _____

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This prescription is valid only if transmitted by facsimile machine by a licensed provider.