Please complete to the best of your ability. Return the completed form to Dalcoma via fax, mail or your benefits officer

Dalcoma Specialty Pharmacy Intake Form

43337 Schoenherr Rd Sterling Heights, MI 48313
Tel: (586) 697-3877 Fax: (586) 697-3878
dalcomapharmacy@gmail.com www.dalcomarx.com

Last Name: _____ First Name: _____ DOB: _____ ☐ M ☐ F
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____

Employer: _____ Yard/Local/Terminal: _____

Insurance Carrier: _____ ID Number: _____ RX Group #: _____ PCN: _____

As your new preferred pharmacy, Dalcoma staff will transfer all medications for you and your family members to our location. Please provide the name and phone number of the pharmacy where you currently receive each medication. When you go to your doctors' appointments you will need to notify the office that you have changed pharmacies and give them our pharmacy information.

Patient Medications

Medication Name	Strength	Current Pharmacy Name	Current Pharmacy Phone Number

Do you have other members in your family who will also get their medications here? ☐ Yes ☐ No
If **Yes** please list family members information on the back of this form.

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Please fill out all the information below for each family member:

Family Members:

Name	Relation to Employee	DOB

Patient Name	Medication Name	Strength	Current Pharmacy Name	Current Pharmacy Phone Number