



Quinlan's Pharmacy Prescription Transfer Form

Name: _____ DOB: _____

Address: _____ Gender: M F

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____

(C) _____ Other _____

Allergies: (circle any that apply)

No known allergies Penicillin Sulfa Codeine Erythromycin

Other: _____

Disease States: (circle any that apply)

Arthritis Diabetes Heart Disease Hypertension Stomach Thyroid

Other: _____

Prescription Insurance: (please fill out information below or attach a copy of your card)

Plan Name: _____ Plan Name: _____

BIN: _____ BIN: _____

PCN: _____ PCN: _____

ID: _____ ID: _____

Rx Group: _____ Rx Group: _____

Relationship: Self Spouse Child Relationship: Self Spouse Child

If you would like Quinlan's Pharmacy to contact your physician to have all of your prescriptions sent to us, please fill in the information below:

The undersigned wishes to have Dr. _____ send all of their current and future prescriptions to Quinlan's Pharmacy Inc., 107 North Main Street, Wayland, NY 14572 effective immediately. Please call (585) 728-2250, fax (585) 728-2198, or electronically transmit all prescriptions to Quinlan's Pharmacy.

Patient Name: (please print) _____ Date: _____

Patient Signature: _____