

Publix Pharmacy Direct Care Enrollment Form

PERSONAL INFORMATION

Patient Name

Address

City

()

State

()

ZIP

Home Phone #

Other Phone #

/ /

Social Security #

Date of Birth

()

Sex

Marital Status

Next of Kin

Emergency Phone #

INSURANCE INFORMATION

Medicare #

Part B Effective Date

Name of Secondary Insurance (Other than or in addition to Medicare)

()

Insurance Phone #

Cardholder ID #

Group #

Name of Policy Holder (if not patient)

/ /

Policy Holder's Date of Birth

Policy Holder's SS #

Employer's Name

City

State

ZIP

MEDICAL INFORMATION

Physician's Name

Address

City

()

State

/ /

ZIP

Phone #

Approximate Date of Last Visit

How many times do you test your blood glucose per day?

Are you currently using insulin? (circle one)

Yes

No

What brand of glucose meter do you own?

Did Medicare cover your present meter?

Yes

No

Are you interested in a new meter?

Yes

No

P U B L I X

P H A R M A C Y

DIRECT CARESM