West Wichita Family Pharmacy
Patient Transfer Form

P: 316-491-6428 F: 316-512-4001

Name _____ DOB _____

Address _____ City _____ State _____

Phone # _____ Cell Phone Carrier _____

Allergies _____ Driver's License # _____

Current Pharmacy Name _____ Pharmacy Phone # _____

NOTE: This form only transfers your scripts.
PLEASE NOTIFY US WHEN YOU ARE READY TO REFILL YOUR 1ST PRESCRIPTIONS.

Would you like for all medications to "sync" to refill on the same day every month? YES NO

Would you like to receive an alert when your prescriptions are ready? CALL TEXT NO

How would you like to receive your prescriptions? We offer free delivery in the west Wichita area.
Pick-up Delivery - Time of day_____

Would you like to review your medications with our pharmacist(s) for education and/or cost saving opportunities? YES NO

Additional Family Members for Transfer:

Name _____ DOB _____

Address _____ Phone # _____

Allergies _____ Driver's License # _____

Current Pharmacy Name _____

Current Pharmacy Phone # _____

Additional Info _____

Name _____ DOB _____

Address _____ Phone # _____

Allergies _____ Driver's License # _____

Current Pharmacy Name _____

Current Pharmacy Phone # _____

Additional Info _____

Please return this form to the pharmacy clinic with a copy of your ID & insurance card.

We look forward to serving you!

Additional Family Members for Transfer:

Name ______________________________ DOB ______________

Address ______________________________ Phone # ______________

Allergies ______________________________ Driver's License # ______________

Current Pharmacy Name ______________________________

Current Pharmacy Phone # ______________________________

Additional Info ______________________________

Name ______________________________ DOB ______________

Address ______________________________ Phone # ______________

Allergies ______________________________ Driver's License # ______________

Current Pharmacy Name ______________________________

Current Pharmacy Phone # ______________________________

Additional Info ______________________________

Name ______________________________ DOB ______________

Address ______________________________ Phone # ______________

Allergies ______________________________ Driver's License # ______________

Current Pharmacy Name ______________________________

Current Pharmacy Phone # ______________________________

Additional Info ______________________________

Name ______________________________ DOB ______________

Address ______________________________ Phone # ______________

Allergies ______________________________ Driver's License # ______________

Current Pharmacy Name ______________________________

Current Pharmacy Phone # ______________________________

Additional Info ______________________________

Phone: 316-491-6428 WEST WICHITA FAMILY PHARMACY **Fax: 316-512-4001**

Please return this form to the pharmacy clinic with a copy of your ID & insurance card.

We look forward to serving you!