



WellDyneRx Mail Order Pharmacy Registration Form

Please use this form to register, add dependents, or update information.
Send completed form to WellDyneRx, P.O. Box 90369, Lakeland, FL 33804.

INSURANCE CARDHOLDER INFORMATION

Last Name		First Name		Mid Int	Date of Birth
Billing Address		City		State	Zip Code
Shipping Address (<input type="checkbox"/> Same as Billing Address)		City		State	Zip Code
Home Phone		Cell Phone		Email Address (to receive information about your prescription orders)	
HomeInstead Rx Saver					
Group Name (Primary) HRX001		Group Name (Secondary)			
Group ID#	Member ID#	Group ID#	Member ID#		

ALLERGIES AND HEALTH CONDITIONS

For your safety, WellDyneRx requires allergy and health condition information for you and your dependents before dispensing medication.
Please enclose additional family member information on a separate piece of paper.

Cardholder Information		Dependent Information		Dependent Information	
First & Last Name:		First & Last Name:		First & Last Name:	
		Relationship to Cardholder:		Relationship to Cardholder:	
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Allergies	Health Conditions	Drug Allergies	Health Conditions	Drug Allergies	Health Conditions
<input type="checkbox"/> No Known	<input type="checkbox"/> No Known	<input type="checkbox"/> No Known	<input type="checkbox"/> No Known	<input type="checkbox"/> No Known	<input type="checkbox"/> No Known
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Asthma	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Asthma	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Asthma
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> COPD	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> COPD	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> COPD
<input type="checkbox"/> Codeine	<input type="checkbox"/> Depression	<input type="checkbox"/> Codeine	<input type="checkbox"/> Depression	<input type="checkbox"/> Codeine	<input type="checkbox"/> Depression
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Penicillin	<input type="checkbox"/> GERD/Ulcer	<input type="checkbox"/> Penicillin	<input type="checkbox"/> GERD/Ulcer	<input type="checkbox"/> Penicillin	<input type="checkbox"/> GERD/Ulcer
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Other*(List below)	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other*(List below)	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other*(List below)	<input type="checkbox"/> Hypertension
	<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Liver Disease
	<input type="checkbox"/> Renal Disease		<input type="checkbox"/> Renal Disease		<input type="checkbox"/> Renal Disease

*Please Specify Patient and Other Drug Allergies:

Medication Preference: WellDyneRx will substitute generic equivalent drugs for brand medications ordered if available and permitted by your doctor. A generic drug has the same effectiveness, quality, safety, and strength, as confirmed by the FDA. Please indicate your preference for brand or generic drugs. If no box is checked, WellDyneRx will substitute generic drugs.

- Substitute generic drugs if available and permitted by my doctor.
- I want to receive brand medications only. I understand that brand medications may be more expensive.

Signature _____ Date _____