My MediCenter Club Enrollment Form

Name (First, Middle Initial, Last): _____

Date of Birth: _____ - _____ - _____ ( ) Female ( ) Male

Address:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Please check if you are allergic to any of the following:

( ) Aspirin ( ) Sulfa ( ) Codeine

( ) Tetracycline ( ) Penicillin ( ) Other (specify) _____

Additional Family Members for Membership:

_____

_____

Would you like to be notified when you have a prescription ready? If so, choose an option below.

☐ Phone Message ☐ Text ☐ Email

Would you like additional information regarding:

- ☐ MedEasy Program (all your medications filled at one time each month)
- ☐ Free Monthly Vitamins for Children and Adults
- ☐ Online Refills, Online Bill Pay, Etc. at www.mymedicenterpharmacy.com
- ☐ Rx2Go Mobile App (Free Mobile App for Smart Phones)
- ☐ Medication Flavoring
- ☐ Compounded Medication
- ☐ Free Delivery

How did you hear about us?

- ☐ Your Healthcare Provider
- ☐ Facebook
- ☐ Newspaper, Television or Radio Ad
- ☐ Referral from a Friend, Family, Colleague, etc.
- ☐ Other: _____

Signature: _____

By joining this club, I authorize MediCenter Pharmacy to track my purchases for the purpose of Loyalty Rewards. This information will never be sold or shared with anyone outside of the company. No part of any prescription filled under the My MediCenter Club will be billed to any insurance company, including Medicare, Medicaid or any other state/federally funded program nor will it be applied to any coverage gap.