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 (☐ Same as Billing Address) | City | State | Zip Code

Home Phone | Cell Phone | Email Address (to receive information about your prescription orders)

ComForCare Prescription Discounts
Group Name (Primary)

CFR222
Group ID# | Member ID#

Group Name (Secondary)

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:	☐ Male ☐ Female	Date of Birth:	☐ Male ☐ Female	Date of Birth:	☐ Male ☐ Female
Drug Allergies	**Health Conditions**	**Drug Allergies**	**Health Conditions**	**Drug Allergies**	**Health Conditions**
☐ **No Known**	☐ **No Known**	☐ **No Known**	☐ **No Known**	☐ **No Known**	☐ **No Known**
☐ Amoxicillin	☐ Asthma	☐ Amoxicillin	☐ Asthma	☐ Amoxicillin	☐ Asthma
☐ Aspirin	☐ Bleeding Disorder	☐ Aspirin	☐ Bleeding Disorder	☐ Aspirin	☐ Bleeding Disorder
☐ Cephalosporins	☐ COPD	☐ Cephalosporins	☐ COPD	☐ Cephalosporins	☐ COPD
☐ Codeine	☐ Depression	☐ Codeine	☐ Depression	☐ Codeine	☐ Depression
☐ Erythromycin	☐ Diabetes	☐ Erythromycin	☐ Diabetes	☐ Erythromycin	☐ Diabetes
☐ Penicillin	☐ GERD/Ulcer	☐ Penicillin	☐ GERD/Ulcer	☐ Penicillin	☐ GERD/Ulcer
☐ Sulfa	☐ Heart Disease	☐ Sulfa	☐ Heart Disease	☐ Sulfa	☐ Heart Disease
☐ Tetracyclines	☐ High Cholesterol	☐ Tetracyclines	☐ High Cholesterol	☐ Tetracyclines	☐ High Cholesterol
☐ Other*(List below)	☐ Hypertension	☐ Other*(List below)	☐ Hypertension	☐ Other*(List below)	☐ Hypertension
	☐ Liver Disease		☐ Liver Disease		☐ Liver Disease
	☐ Renal Disease		☐ Renal Disease		☐ 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