

Patient Registration Form

Fill out the following section if this is your first order with Aetna Rx Home Delivery or if this information has changed.

Please complete the following for EACH family member covered under your Aetna pharmacy benefit. Select "None" for family members with no allergies or health conditions. For your convenience, this information will be included as part of your family's profile with Aetna Rx Home Delivery. We will use this information to check for potential drug interactions and allergies to medications.

FAMILY MEMBER NAME	Allergies							Health Conditions							
	Date Of Birth	Gender (M/F)	None	Penicillin (1)	Chocolate (2)	Sulfa (3)	Aspirin (4)	Thyroid (5)	Diabetes (6)	Glaucoma (7)	Heart Conditions (8)	High Blood Pressure (9)	Ulcer	Epilepsy	Other (please specify)

If you or a family member has diabetes, indicate the type of supplies being used below:

Name	Monitor	Lancets	Test Strips
Name	Monitor	Lancets	Test Strips
Name	Monitor	Lancets	Test Strips
Name	Monitor	Lancets	Test Strips

Please note: By submitting this form, you authorize the release of all the foregoing information to Aetna Rx Home Delivery, LLC, and its affiliates.

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