



If you have any questions or comments about we can best serve your individual needs, please contact us!

**Wegmans Pharmacy #4**  
**851 Fairport Road**  
**East Rochester, New York 14445**  
**Phone: 585-586-7922**  
**Fax: 585-586-0675**

**Patient Information (please print clearly)**

Patient Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F  
Month Day Year

Allergies: \_\_\_\_\_

**Contact Information**

Home Address: \_\_\_\_\_  
Street City State Zip

Cell Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Insurance Information**

Name of Insurance: \_\_\_\_\_ Bin Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

Relationship/Person Code: \_\_\_\_\_

**Authorization for Credit Card Use and Release of Medication**

I understand that I need to contact Wegmans Pharmacy with my credit card information prior to my prescription's delivery. I authorize Wegmans Food Markets, Inc to use and keep my credit card information on file and release my prescription to the Health and Wellness Center at St. John Fisher College. The Health and Wellness Center will hold my prescription until I pick it up or for 10 days, whichever is less. Wegmans Pharmacy is unable to take prescription medication back once it has left the Wegmans Pharmacy counter.

**I will be responsible for payment of the prescription regardless of if it is picked up or not.**

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_