Dear Friends,

My name is Andy Miller and I am pleased to announce that Brattleboro Pharmacy will be opening soon! Brattleboro Pharmacy is an independent pharmacy offering full pharmacy services as well as over the counter products, and other health and beauty aids. We will accept most insurance plans and provide free prescription delivery service. Brattleboro Pharmacy is located at 413 Canal Street, has plenty of parking and is handicap accessible.

I look forward to collaborating with local health care providers and patients with the same amount of professionalism and respect that had occurred in the past and will provide the same personal care and service that customers expect and deserve.

I am eager to open a locally owned business that is invested in Brattleboro, a community that I reside in and value. Brattleboro Pharmacy will be a vibrant community member. Thank you for all of your support in the past and I look forward to meeting your needs in the future

Brattleboro Pharmacy

Please take a moment to fill out this form so we can register you in the computer and contact your pharmacy or doctor to transfer any prescriptions for you once we are open for business.

This form may be mailed to 413 Canal Street, Brattleboro, VT 05301

Or fax directly to the store at 802.254.8444

All information provided will remain confidential. We appreciate your business.

First Name:_____ Last Name:_____

DOB:_____Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____Work/Cell Phone:_____

I authorize the staff of Brattleboro Pharmacy to leave messages regarding my prescriptions at the above listed number: Yes, leave message _____ No messages _____ Signature_____

Medication Allergies (*include reaction if known*):_____

_____

Other Allergies: _____

Chronic Conditions: _____

_____

Child Resistant Caps (please initial): Yes _____ No _____ Signature_____

E-Mail Address:_____

Insurance Name: _____BIN Number_____

RX Group#_____ ID Number: _____

Relationship to Cardholder: _____ ***Please bring your insurance card to your first visit***

If you would like us to transfer prescriptions from another pharmacy please supply the following:

Pharmacy Name: _____Location: _____Phone:_____

Doctor:_____ Medication Names: _____

_____

_____

_____

Other family members/DOB:_____

_____