E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
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Urology

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip:_____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Afinitor®	☐ 2.5 mg tablet ☐ 5 mg tablet ☐ 7.5 mg tablet ☐ 10 mg tablet	☐ Take once daily ☐ Other	☐ 4 week supply ☐ Other	
Afinitor Disperz®	☐ 2 mg oral solution ☐ 3 mg oral solution ☐ 5 mg oral solution	☐ Take once daily ☐ Other	☐ 4 week supply ☐ Other	
Tadalafil	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 20 mg			
Sildenafil	☐ 25 mg ☐ 50 mg ☐ 100 mg			
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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