630 Miluk Drive * PO Box 3190
Coos Bay, OR 97420
(541) 435-7039

COQUILLE INDIAN TRIBAL PHARMACY
MAIL ORDER REGISTRATION FORM

Patient Information

Name:____

Mailing Address: ____

____
Street (PO BOX) City State Zip

Date of Birth: __________________ Male___ Female___
MM/DD/YEAR

Home Phone: (___) _____-______ Cell phone# (___) _____-______

Drug Allergies: ______No ___ Yes (please list): ______________________________

____

❑ ***Please check here if you are a Coquille Tribal Member/Spouse eligible for PRC***

Member of another Federally Recognized Tribe? : Yes___ No ___
If yes, list Tribe:____

I certify that all the information on this form is correct, and authorize the Coquille Indian Tribal Pharmacy to dispense and mail prescriptions according to the parameters of my prescription plan and the information I have provided on this form. I am responsible for notifying Coquille Indian Tribal Pharmacy of any changes to my personal information in order to assure proper delivery and filling of my prescriptions.

____ ________________________

Authorized Signature **Date**

Email this form to citpharmacy@coquilletribe.org or mail to address at the top.