Optum Fax Cover Sheet

Patient's Name:	Sex (circle):	Date of Birth:	Insurance ID #:
Shipping Address:			Phone Number:
City:	State:	Zip:	Alternate Phone Number:

Drug Allergies: ☐ None Known ☐ Others: ________

☐ Penicillin ☐ Cephalosporins ☐ Ampicillin
☐ Sulfa ☐ Erythromycin ☐ Aspirin
☐ Codeine ☐ Tetracycline ☐ Quinolones

Health Conditions: ☐ High Blood Pres. ☐ Others: ________

☐ Diabetes ☐ Arthritis ☐ High Cholesterol
☐ Glaucoma ☐ Asthma ☐ Thyroid Disorder
☐ Osteoporosis ☐ Cancer ☐ Heart Condition

Medication & Strength:

Directions:

Qty

Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 **Other:** ________

Brand Only: ☐ YES

Medication & Strength:

Directions:

Qty

Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 **Other:** ________

Brand Only: ☐ YES

Medication & Strength:

Directions:

Qty

Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 **Other:** ________

Brand Only: ☐ YES

Medication & Strength:

Directions:

Qty

Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 **Other:** ________

Brand Only: ☐ YES

Physician's Name:	NPI:	DEA:
Street:		
City:	State:	Zip:
Phone:	Fax:	
Signature:	Date:	