Patient Information

Name (First)________________________(M.I.)_____(Last)____________________________

Previous last names (if any, such as maiden name)___________________________________

Birth Gender (or Gender on file with insurance company): ☐ Male ☐ Female

Address (Street)______________________________________ (Apt # or PO Box)______________

(City)__________________________ (State)__________________ (ZIP)______________

Birth Date ___________________ Current Age _________ Last 4 Digits of SSN __ - __ - __ - __

We can use your cell # or email to send you text messages about your prescription order IF you would like us to. For instance, we can text you that your order is ready, or that we need your insurance card updated. Note: Due to privacy restrictions, **notification is available for patients age 18 and older**.
If you are age 18 and older, do we have your permission to contact you by cell phone or email?

Circle answer: Yes <or> No If YES, circle preferred: Text message <or> email

Cell Phone ________-________-______________

Other Phone ________-________-______________ Home – Work (circle one)

Email (provide if notification method) ____

Drug Allergies - please give us as much detail as you can recall about the nature of the allergy:

Drug________________________ Problem ____________________________________

Drug________________________ Problem ____________________________________

Drug________________________ Problem ____________________________________

Other medications you are on that are not filled at this pharmacy:

____

____

Chronic medical conditions: ____

____

Do you have difficulty opening child-resistant medication bottles?

☐ Yes, I would like Easy Open caps. (I understand that these are not child-resistant.)
☐ No, I prefer standard child-resistant caps.

I have read and agree to the statements above:

(Signature) ____ (Date)_____________

If you are completing this for another individual, please give us your name and relationship to the patient:

Name_______________________________________ Relationship ____________________

Please include your prescription insurance card and driver's license with this form. (Clerk Initials ________)