New Patient Intake Form

Patient Name:____________________________ DOB:___/___/_____ Male / Female

SSN#:____-____-_____ Driver's License:______________ Preferred Language:_______________

Address:____
Street City State Zip Code

Home Phone: ( ) ____-______ Cell: ( ) ____-______ Cell Provider:__________________
(Verizon,ATT, Straigt Talk, etc)

Email:________________________

How would you like to be notified when your prescriptions are ready? Email / Phone / Text

Would you like your prescriptions to be refilled automatically when they are due? Yes / No

Would you like all of your prescriptions to be ready at the same time every month? Yes / No

Allergies: ____

____

Other Medications:____

____

Medical Conditions: ____

____

Primary Physician: ____

Insurance Information

Primary:__________________Bin:_________ PCN:_________ID:________________Group:____________

Secondary:________________Bin:_________ PCN:_________ID:________________Group:____________

Preferences

☐Do Not Phone ☐Do Not Email ☐Visually Impaired
☐Easy Open ☐Call When Ready ☐Hearing Impaired

Please have your driver's license and insurance cards ready for pharmacy staff

Signature:____________________________ Date:___/___/_____