New Patient Intake Form

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

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

Address:_____
Street City State Zip Code

Home Phone: ( ) ____-_____ Cell: ( ) ____-_____ Carrier:_____

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 ☐Bubble Pack
☐Easy Open ☐Call When Ready ☐Hearing Impaired

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

Signature:_____ Date:___/___/_____