

New Patient Information

Name _____
First Middle Last

Street address _____ City _____ State _____ Zip _____

Phone _____ Social Security # _____

Patient's date of birth _____ Sex M or F

Drug Allergies _____

Emergency contact _____ Phone # _____

Do you have prescription insurance that you would like us to bill ___ Yes ___ No

If yes, please show your card before we fill your prescription.

Do you want child resistant tops on your prescriptions? ___ Yes ___ No

Medical Information

Check all that apply

Allergies

___ No known Allergies (000)

___ Penicillin (001)

___ Sulfa Drugs (015)

___ Aspirin (003)

___ Tetracycline (007)

___ Codeine (004)

Other (list below)

Conditions

___ Angina

___ Anemia

___ Arthritis

___ Asthma

___ Breast Feeding

___ Cancer

___ Diabetes

___ Epilepsy

___ Glaucoma

___ Hay Fever

___ Heart Condition

___ Kidney Disease

___ Liver Disease

___ Pregnant

___ Prostate Condition

___ Respiratory Condition

___ Thyroid Condition

___ Ulcers

___ Other (list below)

Medications

Please list all prescription and non-prescription medications that you are currently taking.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

It is your responsibility to inform our pharmacy of any changes to your medical profile.

Dear Patient,

We are glad to have you join our team. It is important for your Pharmacist to know all the medications you are taking. Some medicines react with others and this could be dangerous.

By signing below you are agreeing to advise us of all medicines you are taking. We are here to give you

PERSONAL – FAST – CONVENIENT SERVICE.

Thanks, Truette Dobson

I understand and agree to everything above. **Your Signature** _____