

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** \_\_\_\_\_