Buena Vista Drug
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SALIDA PHARMACY & FOUNTAIN
EST. 2019

Whole Patient Care Program Intake Form

Our pharmacy team will work with you to coordinate your medications to be on the same monthly pick up cycle and check in with you during every check in call to help you meet your health goals.

PATIENT INFORMATION

Last Name:_____ First Name: _____ MI: ____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone #: (_____) _____-_____ □ Mobile □ Work □ Home

Secondary Phone #: (_____) _____-_____ □ Mobile □ Work □ Home

Preferred Contact Method: □ Phone □ Text □ Rx Local Mobile App □ Email

Prescription Benefit Plan Name:

_____

Member ID #: _____ Group #: _____ BIN #:

_____ PCN: _____

MEDICATION ALLERGIES

□ No known allergies □ Aspirin □ Codeine □ Iodine □ Quinolones □ Tetracyclines

□ Amoxil/Ampicillin □ Cephalosporins □ Erythromycin □ Penicillin □ Sulfa Drugs

□ Others: _____

HEALTH CONDITIONS

□ None □ Asthma □ Epilepsy □ High blood pressure □ Osteoporosis □ Others: _____

□ Acid Reflux □ Depression □ Glaucoma □ High cholesterol □ Prostate issues

□ Arthritis □ Diabetes □ Heart problem □ Migraine □ Thyroid – low / high

Medication/Vitamin/Supplement List

Please list all medications/vitamins/supplements you take and how many times per day (frequency) and what time of day you take your medication and if the medications are regularly scheduled or taken as needed.

Drug /Vitamin/Supplement	Strength	Frequency	Time of Day	Scheduled (y/n)	As Needed (y/n)

We also offer strip packaging in which we sort and package your medications into individual pouches based on the day, dose and the time you take your medications. Would you be interested in learning more about medication packaging?

□ Yes
□ No

Are you interested in medication delivery to your home or office?

□ Yes
□ No

Signature/Guardian: _____ Date: _____