137 F Street
Salida, CO 81201
info@salidapf.com

We are excited to be brining you a more personalized and caring pharmacy experience. Providing us this information will allow our team to provide a smooth transition to our pharmacy.

New Customer Intake Form

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

Driver's License # / Exp Date:_____ 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

Allergies: _____

Primary Physician: _____

Insurance Information

Primary:_____ Bin:_____ PCN:_____ ID:_____ Group:_____

Do you have other family members that live in the same household?

Name: _____ DOB: _____/_____/_____ Relation: _____

Name: _____ DOB: _____/_____/_____ Relation: _____

Name: _____ DOB: _____/_____/_____ Relation: _____

Please return this form:
Drop Off @137 F Street | Mail: PO Box 1670 Buena Vista, CO 81211 |
Email: info@salidapf.com | Fax: 719-395-2484