New Patient Form

Patient Name: _____ DOB: _____/____/_____

SSN: _____-____-_____ (Optional) Gender: ___ Female ___ Male

Preferred Language (Circle or Write): English or _____

Address: _____

(Street, City, State, Zip Code)

Email: _____ Allergies: _____

Cell: _____ Home Phone: _____

How would you prefer to receive messages (Circle)? Cell Home Email Text

Who is your Primary Care Provider? _____

Medications and Supplements

Name And Strength	How Taken (Ex: AM, PM)	Condition Medication Taken For	Physician who Prescribed Med	Notes

The information provided is true and correct to the best of my knowledge. I acknowledge that I am seeking medical advice from Healthy Life Pharmacy. The advice given is not regulated or endorsed by the FDA. I am aware that these services are not currently eligible to be paid for by my insurance and I am responsible for any and all payments due at the time of the appointment.

_____ _____

Signature Date

New Patient Form

Medications and Supplements (Continued if Needed)

Name And Strength	How Taken (Ex: AM, PM)	Condition Medication Taken For	Physician who Prescribed Med	