207 E Main St, Remington, VA 22734 ● Toll Free: 800.675.8041 ● Ph: 540.439.3247 ● Fax: 540.439.9822 ● Email: info@remingtondrug.com

Pharmacy Intake Form

Welcome to Remington Drug! Please complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

_____ _____ _____ ☐ M or ☐ F _____ / _____ / _____

First Name M.I. Last Name Date of Birth (MM/DD/YYYY)

_____ _____

Street Address / P.O. Box / Billing Address (Circle One) City

_____ _____ (_____) _____ (_____) _____

State Zip Code Home Phone Cell or Work Phone *(Please circle one)*

Email Address _____ SSN: _____-_____-_____

ALLERGIES: ☐ No Known Allergies ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Erythromycin ☐ Peanuts

OTHER: _____

CURRENT OVER-THE-COUNTER/HERBAL PRODUCTS:

_____

CURRENT MEDICAL CONDITIONS: ☐ High Blood Pressure ☐ Diabetes (Type I), Diabetes (Type II)

☐ High Cholesterol ☐ Asthma ☐ Epilepsy ☐ Arthritis ☐ Depression ☐ Headaches ☐ Glaucoma

☐ Smoking ☐ Pregnancy (Due :_____) Breastfeeding ☐ No known Medical Conditions

OTHER: _____

CHILD RESISTANT PACKAGING:

I request to have my prescriptions dispensed in ☐ CHILD RESISTANT *or* ☐ EASY OPEN caps. I also received the Notice of Privacy Practices.

I, _____, attest that the information provided above is accurate and I understand that Apothecary Solutions Inc dba Remington Drug Co may / will contact my provider(s) for medications or services they provide. I authorize Apothecary Solutions Inc dba Remington Drug Co to provide me with medication information or marketing material via TEXT message, E-MAIL or TELEPHONE. I agree that I am responsible for payment of medications or services provided by Apothecary Solutions Inc dba Remington Drug Co.

_____ _____

Signature Date (MM/DD/YYYY)

HOW DID YOU HEAR ABOUT US: ☐ **Facebook** ☐ **Internet (Google)** ☐ **Word of Mouth** ☐ **Drove By** ☐ **Radio** ☐ **Email**

Other:_____