Date: _____

MCGLYNN PHARMACY INTAKE FORM

(Information is to be filled out for the person getting the prescription)

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____ Sex: Male Female
Drug Allergies: _____
Insurance: yes no **-if yes please present insurance card**

Please initial/fill out the items below that you would like:

I would like non-safety/easy open caps on my prescription bottles: (Initial) _____
I would like to have my prescription(s) automatically refilled when due:
(Initial) _____

I would like the option to be notified when my prescription(s) are ready to be picked up:
Via Email: _____
(For contact concerning Rx's only – not for promotional purposes)

Via Text Message-Cell Phone: _____
(Data fees may apply)

If person above is a minor, please list family primary contact:
Name: _____D.O.B:_____

Please list any other immediate family members that you would like to receive pick up notifications for below:

Name: _____D.O.B:_____
Name: _____D.O.B:_____
Name: _____D.O.B:_____
Name: _____D.O.B:_____
Name: _____D.O.B:_____
Name: _____D.O.B:_____