Southland Pharmacy

New Patient Intake Form

Patient Name:________________________ DOB___/___/_____

SSN#____-___-____ Driver's Lic.#______________ D.L. Exp___/___/_____

Address:_________________________________City/ZIP:____________________

Mobile Phone:__________________ Home Phone:_______________________

Email: ____

Allergies and Reactions:____

All Medications:____

Medical Conditions:____

Primary Care Physician:____

How did you hear about Southland?_____________________________________

Current Pharmacy and City for Transfers ***_____________________________

- Would you like to receive notifications when your meds are ready?
  - Yes or No
- Please have your driver's license and insurance cards ready for pharmacy staff.
- You can easily order refills through our APP, WEBSITE or PHARMACY PHONE SYSTEM. Download our app while you are here.

Welcome to Southland Pharmacy!

Signature____________________ Date___/___/____

*****If we fill a controlled medication for you, we are required to fill all of your medications here as well.**