HOMER DRUGS

Form # 702

Please complete and return to the Pharmacy Staff. To provide the highest level of pharmacy care this information is requested by your pharmacist or required by state regulation. This is confidential patient information.

Patient's Last Name (Please Print) First Name Middle Initial	Area Code and Home Phone Number: ( ) -
Street Address Apartment #	Area Code and Work Phone Number ( ) -
City, State & Zip Code	Area Code and Mobile Phone Number ( ) - circle your mobile carrier – we need this to send text notifications when your prescription is ready. ATT Verizon Sprint T-mobile MetroPCS
How did you hear about us? ☐Word of Mouth – If so, from who_____ ☐Vitamin Program ☐ Newspaper ☐ Radio ☐ Roadside sign ☐RxSync Program ☐Packaging ☐Other _____	Sex: ☐ Male ☐ Female
Email Address: / Date of Birth: Mo/Day/Year	Social security Number

Medical Information

Allergies: Please check all known allergies, including symptoms.

- ☐ NO KNOWN ALLERGIES/DRUG REACTIONS
- ☐ Aspirin I experienced _____
- ☐ Cephalosporins I experienced _____
- ☐ Codeine I experienced _____
- ☐ Erythromycin I experienced _____
- ☐ Food Additives or Dyes I experienced _____
- ☐ Penicillins I experienced _____
- ☐ Ibuprofen I experienced _____
- ☐ Morphine I experienced _____
- ☐ Sulfa Drugs I experienced _____
- ☐ Tetracyclines I experienced _____
- ☐ Xanthines I experienced _____

OTHER ALLERGIES:

Health Conditions
(Please check the health condition(s) that apply:

- ☐ Angina ☐ Anemia
- ☐ Arthritis ☐ Asthma
- ☐ Blood Clotting disorders
- ☐ Blood Pressure, High
- ☐ Breast Feeding
- ☐ Cancer ☐ Ulcers
- ☐ Cholesterol, High
- ☐ Depression
- ☐ Diabetes (Insulin dependent)
- ☐ Diabetes (Non-Insulin dependent)
- ☐ Digestive conditions
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Hypo-Thyroid Conditions
- ☐ Hyper-Thyroid Conditions
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Conditions
- ☐ Migraine
- ☐ Parkinson's Disease
- ☐ Currently Pregnant
- ☐ Prostate Cancer
- ☐ Other Health Conditions:

What other medications are you currently taking? (Include all over-the-counter medications and vitamins:

Since Information may change periodically, please notify us of any new medications (Rx or OTC), allergies, drug reactions or health conditions. By signing below I am indicating that the above information is correct and that I wish to enroll in the loyalty program at Homer Drug Co.

_____ _____

Signature Date Relationship to Patient

I do not wish to provide this information and/or enroll in the HDC loyalty program. _____

Signature Date