Patient Information Form

To provide the most complete and accurate pharmacy care this information is needed by the pharmacist

Patient's Last Name (please print) First Name Middle Name Phone Number

Street Address Sex Work Number

Address Line 2 Language Cell Number

City, State and Zip Code Date of Birth (month/day/year)

Social Security Number (only if no Insurance card on file) Email Address

Allergies

(Please check all that apply, describe reaction on back of sheet)

☐ No Known Allergies ☐ Codeine ☐ Morphine ☐ Sulpha Medications
☐ Aspirin ☐ Erythromycin ☐ NSAIDS (ibuprophen, Naxopren) ☐ Tetracyclines
☐ Cephalosporin (Keflex, Ceclor) ☐ Food Additives/Dyes ☐ Penicillin ☐ Xanthines (Theophyline)
☐ Other Allergies: _____

Have you had These Vaccines?

Pneumonia_____ Shingles_____ Flu_____

Health Conditions

☐ Anemia ☐ Blood Clotting Issues ☐ Epilepsy ☐ High Cholesterol ☐ Pregnancy
☐ Angina ☐ Cancer ☐ GERD ☐ Kidney Disease ☐ Prostate Disease
☐ Arthritis ☐ Depression ☐ Glaucoma ☐ Liver Disease ☐ Thyroid
☐ Asthma ☐ Diabetes ☐ Heart Condition ☐ Lung Conditions ☐ Ulcers
☐ Breast Feeding ☐ Emphysema ☐ High Blood Pressure ☐ Migraine
☐ Other Conditions: _____

List any other medications, over the counter medications, vitamins, and herbals

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED DUNWOODY PHARMACY NOTICE OF PRIVACY PRACTICES AND AGREE TO THE PROVISIONS SET FORTH IN THIS DOCUMENT. THEREFORE, I HEREBY GIVE DUNWOODY PHARMACY PERMISSION TO DISCLOSE TO ANY OTHER ENTITY, MY PROTECTED HEALTH INFORMATION WHEN DUNWOODY PHARMACY FEELS THAT IT IS IN MY BEST INTEREST OR SERVES A PURPOSE TO ASSIST OR AID IN MY HEALTHCARE.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____