McNeill's Pharmacy

North Carolina's Oldest Pharmacy

Thank you for choosing McNeill's Pharmacy to care for you! We look forward to having you as part of our McNeill's Pharmacy family. Please feel free to reach out to our pharmacy staff with any questions or concerns you may have, we are always here to assist you!

Attached are forms that you must complete for the pharmacy to begin to process, fill, package, and provide you with your medications. These documents will also be utilized to create your patient profile. These forms are confidential and will be kept on file at McNeill's Pharmacy for pharmacy personnel only. Please complete the following forms and fax or email to the pharmacy.

Sincerely,

McNeill's Pharmacy

Phone: 910-642- 3065 ***Fax: 910-642-3765***

Toll Free: 866-908-3009

Email: mcneillspharmacy@earthlink.net

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PATIENT DEMOGRAPHICS & INFORMED CONSENT

On behalf of McNeill's Pharmacy, thank you for allowing us to play a vital role in the management of your health! By completing the following information, you are allowing McNeill's Pharmacy the right to receive, process, fill, dispense, and/or mail your prescriptions to you or a person designated to managing your care.

Patient Information:

First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: ___/___/___

Sex/Gender (circle): Male / Female Social Security Number: _____

Current Address:

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Allergies: _____

Caregiver/Other Contact:

Name: _____

Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

Primary Care Provider:

Name:_____ Office Number:_____

Previous Pharmacy:

Name: _____ Phone Number: _____

By my signature below, I authorize consent that I have received information regarding the services and use of McNeill's Pharmacy. By signing I am giving permission for McNeill's Pharmacy to receive, process, fill, and dispense my prescriptions.

Print Name: _____

Signature: _____ Date: _____

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YOU MAY FILL OUT THE INSURANCE INFORMATION TABLE AND FAX/EMAIL TO US OR SIMPLY FAX/EMAIL A PHOTO OF THE FRONT & BACK OF YOUR INSURANCE CARD WITH THIS INFORMATION PACKET.

Insurance Information

BIN	
PCN	
Group Number	
ID Number	

Card Information for Medication Copay

Name on Card	
Credit or Debit	
Credit Card Number	
Expiration Date	
CVV Code	

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Safety (Child Resistant) Container Waiver

Patient Name: _____ *Date*_____

I voluntarily request that McNeill's Pharmacy (located at 620 Jefferson Street, Whiteville, NC 28472) package ALL of my prescriptions in non-safety/non-child resistant containers. I understand and acknowledge that all drugs should be kept out of reach of children and that misuse of the prescription by me, or others, may cause serious side effects, injury, or death.

I assume all responsibility for the use of non-safety/non-child resistant containers for my prescriptions and will not hold McNeill's Pharmacy liable for any adverse event that may result from misuse of my prescriptions due to the execution of this waiver.

_____ _____

Signature of Patient/Legal Representative *Date*

_____ _____

Witness *Date*