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We are excited to be brining you a more personalized and caring pharmacy experience. Providing us this information will allow our team to provide a smooth transition to our pharmacy.

New Customer Intake Form

Patient Name:_____ DOB:___/___/_____ Male / Female

Driver's License # / Exp Date:_____ Preferred Language:_____

Address: _____
Street

_____
City State Zip Code

Home Phone: ( ) ____-_____ Cell: ( ) ____-_____ Carrier:_____

Email:_____

How would you like to be notified when your prescriptions are ready?
Email / Phone / Text

Allergies: _____

Primary Physician: _____

Insurance Information

Primary:_____ Bin:_____ PCN:_____ ID:_____ Group:_____

Do you have other family members that live in the same household?

- O Pick up all your medications at once (Med Sync)
- O Blood pressure monitoring
- O Diabetic self-managing education
- O Vitamin and supplement consulting
- O Medication Delivery or Mail