

**PATIENT PROFILE**

Patient Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street

Male \_\_\_\_ Female \_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Please check:  Home  Cell  Work  
By providing your telephone number, you agree to receive pickup notifications, refill reminders, vaccine information, and other pharmacy-related information via automated calls or texts.

How would you like to be notified when your prescription is ready?  Phone  Text  Email

Email: \_\_\_\_\_

Would you like your maintenance medications auto-refilled? Yes \_\_\_\_ No \_\_\_\_  
(This option is not available for Medicaid, Medicare Part B, or controlled prescriptions).

Do you have a prescription insurance card? Yes \_\_\_\_ No \_\_\_\_ **If Yes, please present card.**

Would you like an easy open top on your prescription? **\*(INDICATE WITH INITIALS)\*** Yes \_\_\_\_ No \_\_\_\_  
This is not an option for children's prescriptions. By indicating yes with your initials you accept liability for any children in your household. Anyone with children in their household should specify no on this question.

Are you allergic to anything? (Please Check Below)  No Known Allergies  
 Aspirin  Tetracyclines  
 Penicillin  Sulfa Drugs  
 Cephalosporins  Codeine  
 Erythromycin  Other Please specify \_\_\_\_\_

Please list any non-prescription products you are currently using.  
\_\_\_\_\_  
\_\_\_\_\_

Please list any prescription drug you are currently using not purchased from this pharmacy.  
\_\_\_\_\_  
\_\_\_\_\_

What health conditions currently affect you?  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Date

Accepted by: \_\_\_\_\_