PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Phone # (_____) _____ ☐ SHIP ☐ PICKUP

Shipping Address _____

City _____ State _____ Zip _____

Email _____ Driver's License_____

MEDICAL INFORMATION (check all that apply)

Do you have any medical conditions that we should be aware of? If none, reply NONE

_____

_____

DRUG ALLERGIES *(please list)*

If none, reply NONE

_____

_____

PRESCRIPTION INSURANCE ☐ Yes ☐ No

Please note – We may ask you to text or email a photo of your insurance card.

Insurance Company _____

ID or Member #: _____ Rx Group #: _____

Bin #: _____ PCN #: _____

Please email completed form to: getit@thefallspharmacy.com