PORT ALLEGANY PHARMACY Rx

New Patient Profile

Please Print All Information

Name: _____ Phone Number: (_____) _____-_____

Address: _____ Date of Birth: _____/_____/_____

_____ Email: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____

Emergency Contact Number: (_____) _____-_____ Would you like safety caps on your medication? _____ Yes _____ No

Do you have any drug allergies? ____Yes ____ No

If Yes, please list:_____

Were you referred to Port Allegany Pharmacy by a friend or family member? _____Yes ____ No

If Yes, please provide their name: _____

If you were not referred by a friend or family member, how did you hear about us?

_____

***If you have prescription insurance coverage, please present your insurance card.

Please list any medications you are currently taking that you did not obtain from Port Allegany Pharmacy.

_____

_____

By signing below, I indicate that I have received a copy of the Port Allegany Pharmacy Privacy Rules of Personal Health Information and H.I.P.A.A. regulations and all information given above is true to the best of my knowledge.

_____ _____

Patient Signature Date