PORT ALLEGANY PHARMACY Rx

New Patient Profile

Please Print All Information

Name: _____

Address: _____

_____

City: _____

State: _____ Zip: _____

Phone Number: (_____) _____-_____

Date of Birth: _____/_____/_____

Email: _____

Drivers License #_____

SSN # _____ - _____ - _____

Emergency Contact: _____

Emergency Contact Number: (_____) _____-_____

Would you like safety caps on your medication?

_____ Yes _____ No

Would you like to receive notifications via:

_____ Text (Wireless Carrier: _____)
**standard text messaging rates may apply*

_____
(Mobile Number)

_____ Email

Do you have any drug allergies?
____Yes ____ No

If Yes, please list:_____

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

_____

_____

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, how did you hear about us? _____

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

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