Dedrick's
PHARMACY + GIFT SHOP

PATIENT INFORMATION

LAST NAME:_____ PERMANENT ADDRESS:_____

FIRST NAME:_____ CITY:_____

MIDDLE INITIAL:_____ STATE/ZIP:_____

DATE OF BIRTH:_____ LOCAL ADDRESS:_____

AGE:_____ CITY, STATE/ZIP:_____

PHONE NUMBER:_____ EMAIL:_____

MEDICATION ALLERGIES: PLEASE LIST REACTION (RASH, NAUSEA, ,ETC) FOR ANY ALLERGY

_____

_____

NOTE: PLEASE BRING YOUR PRESCRIPTION INSURANCE CARD. MANY PRESCRIPTION INSURANCE CARDS WILL BE DIFFERENT THAN YOUR MEDICAL INSURANCE CARD.

Primary Care Physician(PCP):

Name of PCP:_____

Contact Information (phone number, address):_____

_____

_____ _____

PATIENT (REPRESENTATIVE) SIGNATURE DATE

For Pharmacy Use Only:			
Notice of Privacy Practices: I hereby acknowledge that I have received Dedrick's Pharmacy's Notice of Privacy Practices.			
I hereby acknowledge I received the prescription number listed below			
RX NUMBER	PATIENT NAME	PATIENT SIGNATURE	DATE