New Patient Information Sheet :

E-mail to info@friendlypharm.com, fax to 336.763.0693 or bring in to the pharmacy. Thank you!

Full Patient Name: Last _____ First _____ MI _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Date of Birth: _____ Gender: _____

Preferred Method of Contact: _____

Brief Medical History Questions:

Please answer the following questions so we may know more about your health history.

Medication Allergies: _____

Medical Conditions: _____

Regular Physician: _____ Physicians Phone #: _____

SAFETY (Childproof) Caps? ☐ Yes ☐ No

Would you like for us to contact your current pharmacy to transfer medications? ☐ Yes ☐ No

If YES, please provide the pharmacy name and location. _____

_____

How would you like for us to notify you when your prescription is ready? ☐No Contact Necessary

☐ Phone Msg (preferred #) _____ ☐ Text* (preferred #) _____

*Please list your service provider (AT&T, Verizon, etc). _____

☐ Email (preferred email) _____

Insurance & Identification:

Information to be kept on file.

Prescription Insurance Plan Name: _____

BIN #: _____ PCN #: _____ RX Group: _____

Card Holder ID #: _____

Relationship of Patient to Card Holder (self, spouse, child, etc.): _____

Driver's License #: _____ DL State: _____ DL Expiration Date: _____

SSN: _____