New Patient Intake Form

Name:____**Date of Birth**:______________

Address:____

City:____**State**: __________**Zip**: _____________

Driver's License:______________________________E-Mail:________________________________

Cell Phone: __________________________________**Day Phone**:_________________________________

Would you like to receive text message or email notifications that your prescriptions are ready? Yes or No

Do we have your permission to mail or deliver your prescriptions upon request? Yes or No

Would you like to receive your medications with a NON-Safety cap (easy open)? Yes or No

Would you like to enroll in our Simplify My Meds (sync) program? Yes or No

Insurance:______________________________ID:____

RX Group: BIN: PCN: Phone #________________________

SSN:____

Allergies:____

Chronic Conditions: High Blood Pressure High Cholesterol Diabetes

Thyroid Disorder

Other Chronic Condition(s):____

Please list over the counter medications (including supplements) you take each day:

____

____

____

I acknowledge of receipt of Sixth Avenue Medical Pharmacy's Notice of Privacy Practices

Signature:____**Date**:__________________

Thank you so much for your time! The Sixth Avenue Medical Pharmacy Staff (5-17)