Sixth Avenue
MEDICAL PHARMACY
Your trusted neighborhood pharmacy since 1964

New Patient Intake Form

Name:_____**Date of Birth**:_____

Address:_____

City:_____**State**: _____**Zip**: _____

Driver's License:_____E-Mail:_____

Cell Phone:_____**Day Phone:**_____

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

***If yes, please circle your preference (**text or email**)*

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

Would you like your medications with an easy open lid or in bubble packs? Yes or No

Would you like to enroll in our medication synchronization program? Yes or No

Allergies:_____

Insurance:_____ID:_____

RX Group:_____BIN:_____PCN:_____Phone #_____

SSN:_____

Chronic Conditions:

___ Anxiety ___Arthritis ___Asthma _____Cancer
___Chronic Pain ___Depression ___Diabetes _____Thyroid
___High Blood Pressure ___High Cholesterol
___Menopause/Hormone Disorders ___Seizure Disorder /Epilepsy

Other Chronic Condition(s):_____

Please list all medications you take regularly which are not on file at 6th Avenue Pharmacy. Use back of sheet if necessary.

_____

_____

_____

_____

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

Signature:_____**Date:**_____

THANK YOU for your time and for choosing us as your pharmacy.
The information we obtain helps us evaluate your medications, side effects and interactions and provide you with the best, most efficient pharmacy care.

The Sixth Avenue Medical Pharmacy Staff (6/6/2019)