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: ____________