Rice's Pharmacy
New Patient Information Form

Date: ____________ Preferred Patient Name: ____
FIRST Middle Initial LAST

LEGAL Name (if different than above): ____
FIRST Middle Initial LAST

Birth Date: _________________ Identified Gender: ____________ Legal Gender: ________________
MM / DD / YYYY (if different from Identified Gender)

Preferred Pronoun(s): _______________ SSN ________________ Medicare # ____________________

Address: ____
STREET CITY STATE ZIP

Contact / Phone #(s) ____
PRIMARY # WORK # OTHER #

Would you like to be signed up for text alerts? (Circle one) YES / NO

(If in Facility / Assisted Care,)
Responsible Party / Contact Person: ____
NAME of Caregiver / Power of Attorney (provide copy of P.oA.) and Phone number

Would you like EASY OPEN Caps? (Circle one) YES / NO / Don't Care

DRUG Allergies: ____

____

Other Allergies (Food, Environmental, Dyes ... etc.): ____

____

Health Conditions: ____

____

Do you have INSURANCE with Rx coverage? (Circle one) YES / NO If YES, please SHOW insurance card

**If you DON'T have your insurance card, please provide SSN above (or) provide the following:

RxBIN PCN ID #

RxGROUP Person code

Have you been offered our Privacy Policy (HIPAA)? (Circle one) YES / NO If NO, Please inform Pharmacy Clerk

Would you like to authorize other people to pick up? (Circle one) YES / NO If YES, please inform Pharmacy Clerk