RICE'S PHARMACY - NEW PATIENT INFORMATION FORM

Date: _____ Preferred Patient Name: _____
FIRST Middle Initial LAST

Name of LEGAL DOCUMENTS (if different than above): _____
FIRST Middle Initial LAST

Birth Date: _____ Identified Gender: _____ Legal Gender: _____
MM / DD / YYYY (if different from Identified Gender)

Used 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 PH #

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

List DRUG Allergies (or say none) : _____

_____

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

_____

List Chronic Health Conditions (or say none) : _____

_____

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