Pharmacy Intake Form

Welcome to Jones Pharmacy! Please take a few moments to complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

First Name M.I. Last Name Date of Birth (MM/DD/YYYY)

Street Address State Zip Code

Home Phone Work Phone

Weight (*required for children) _____ pounds

Insurance Name and ID#

ALLERGIES: ❒ No Known Allergies ❒ Penicillin ❒ Sulfa ❒ Codeine ❒ Peanuts ❒ Other: _____

CURRENT OVER-THE-COUNTER/HERBAL PRODUCTS: _____

CURRENT MEDICAL STATUS: ❒ High Blood Pressure ❒ Diabetes ❒ High Cholesterol ❒ Asthma
❒ Chronic Pain ❒ Arthritis ❒ Depression ❒ Headaches ❒ Glaucoma ❒ Smoking: _____
❒ Pregnancy (Due: _____) ❒ Breastfeeding OTHER: _____

CHILD RESISTANT PACKAGING:

I request to have my prescriptions dispensed in CHILD RESISTANT ❒ or EASY OPEN ❒ caps.

Signature Date (MM/DD/YYYY)

EMERGENCY CONTACT (Person eligible to receive Patient Health Information):

Name Relationship (____)_____
Telephone

PRIVACY POLICY ACKNOWLEDGEMENT:

I have read and understand the privacy policies of Jones Pharmacy and Home Health Care Center and accept the outlined policies and procedures.

Signature Date (MM/DD/YYYY)

Pharmacy Use Only: