FIRSTHEALTH OUTPATIENT PHARMACY
CONFIDENTIAL PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME:_____ MI:_____

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE: _____ WORK/MOBILE PHONE:_____

BIRTH DATE:_____ __MALE __FEMALE EMAIL ADDRESS:_____

_____EMPLOYEE_____EMPLOYEE DEPENDENT_____VOLUNTEER_____DISCHARGE PATIENT _____RETIREE_____OTHER

DO YOU HAVE PRESCRIPTION INSURANCE? __YES __NO

INSURANCE PROVIDER NAME:_____ BIN NO. _____

CUSTOMER ID#_____ GROUP#_____

DRUG ALLERGIES: (CHECK ALL THAT APPLY) _____NONE_____ASPIRIN_____CODEINE _____IBUPROFEN

_____SULFA _____PENICILLIN OTHER:_____

SIGNATURE:_____ DATE:_____

IT IS ALWAYS IMPORTANT TO NOTIFY YOUR PHARMACY OF ANY CHANGES IN YOUR MEDICAL HISTORY

IF YOU NEED A PRESCRIPTION TRANSFERRED FROM ANOTHER PHARMACY PLEASE COMPLETE THE INFORMATION BELOW:

PHARMACY NAME:_____

PHARMACY PHONE:_____

PRESCRIPTION NUMBER(S)/NAME OF MEDICATION(S):_____

_____

_____

_____

_____

OTHER INSTRUCTIONS:_____

_____

_____

_____

FIRSTHEALTH OUTPATIENT PHARMACY WILL CONTACT YOUR PHARMACY TO OBTAIN ALL NECESSARY INFORMATION

COMPLETED FORM MAY BE FAXED TO **(910) 715-4255**

FirstHealth
OUTPATIENT PHARMACY