PATIENT QUESTIONNAIRE

Patient Name ________________________________SSN_________________________

Address ____

City, State, Zip ____

Home Phone ___________________________ Cell Phone _______________________

Email ____ DOB ______/ ______/ _______

Drug allergies: ____

Bottle cap preference: Child Resistant caps __________ Non-lock caps _____________

Are you allergic to any dyes? Yes ______ No ______

If yes, which ones? ____

Are you lactose intolerant (allergic to milk)? Yes ______ No ______

Would you like your maintenance medications on Auto-Refill? Yes ______ No ______

Would you like a text or email notification when your prescriptions are ready? Y___ N___

Choose: text _____ email _____ both _____

How did you hear about us? ____

Please provide a copy of your prescription insurance card.