PATIENT INFORMATION SHEET

Please complete all fields

PATIENT NAME:_____

Date of Birth: _____/_____/_____ ❑ **MALE** ❑ **FEMALE**

Driver's License # _____**State**_____ **Exp**_____
***Certain medications require this information at time of pickup**

Mailing Address:_____

Delivery Address: _____

Phone 1: (_____**)**_____**-**_____ ❑**Home** ❑**Cell** ❑**Work**

Phone 2: (_____**)**_____**-**_____ ❑**Home** ❑**Cell** ❑**Work**

Allergy Information:_____

Safety Cap Lids ❑ **Yes** ❑ **No**

❑ **Yes, I have prescription insurance *Please present insurance information with this completed form**
❑ **Yes, I would like TEXT NOTIFICATION when my prescriptions are ready for pick-up to: Phone 1 or 2**

How did you hear about our pharmacy? (please check all that apply)
❑ **Friend/Family** ❑ **Doctor** ❑**Social Media** ❑**Advertisement** ❑**Other**_____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person(s) is/are authorized *to use or disclose* information about me:

   _____

2. The following specific person(s) may receive disclosure of protected health information about me:

   _____

3. I may revoke this authorization by notifying King's Pharmacy in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

_____ _____
Signature of Patient *or **Date**

_____ _____
***Legal Guardian of Patient** **Relationship to Patient**

Where Service is not a thing of the past