HAPPY HOOVES FAMILY PHARMACY

New Patient Intake Form

Section 1: Patient Information

Name: _____ DOB: _____ Sex: F / M

Mailing Address: _____

Phone #: _____

Email: _____

Section 2: Insurance Information

Insurance Company: _____

Primary Card Holder Name: _____

Insurance ID #:_____ Rx PCN: _____

Rx BIN: _____ Rx Group:_____

Additional Coverages (Including coupon or savings card):

_____

_____

Section 3: Prescription Preferences

Packaging: ❒ Bottle ❒ Med Pack

Day Supply: ❒ 30 Day ❒ 90 Day

Automatic Refills: ❒ Yes ❒ No

Prescription Reminder: ❒ Text ❒ Call ❒ Email

Delivery Method: ❒ In-Store ❒ Curbside ❒ Fed-Ex/USPS ❒ Driver

Section 4: Current Medical History:

Medical Conditions: _____

Medications: _____

_____

Medication/Food Allergies: _____

Doctors: _____

_____+

Signature Date

***By signing above, I acknowledge receipt of Happy Hooves Family Pharmacy's Notice of Privacy Practices