NEW PATIENT FORM

PARISH PHARMACY

Phone: 225.327.1018
Fax: 225.327.1019

To help ensure that our patient records are accurate and up-to-date, please complete this form in its entirety and return it to the pharmacist for processing. This information is vital for prescription processing and will remain strictly confidential. Incomplete forms will not be honored. When complete, please turn it in to a pharmacy staff member. Thank you for shopping at Parish Pharmacy!

Please print clearly. Use a separate sheet for each patient.

First Name: _____ Last Name: _____ M.I. _____

Street/Apt. No: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Mobile: _____

Sex: ☐ Male ☐ Female Email: _____

Birth Date: _____ SSN (optional): _____ _____ _____

Would you like to receive electronic prescription updates? ☐ Yes ☐ No

Check One: ☐ Text ☐ Email ☐ Voice

Drug Allergies

Please check all that apply

- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

Please Specify: _____

_____

_____

Pre-Existing Conditions

Please check all that apply

- ☐ Angina
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Other

Please Specify: _____

☐ **Pick-up** ☐ **Delivery** ☐ **Mail-to-Home**

Current Medications to be Transferred:

Medication Name & Rx Number	Pharmacy Name & Phone #	Date to be Filled

Do you have a prescription care that pays for your prescriptions? ☐ Yes ☐ No

Ins Card ID #: _____ Name of cardholder if not self: _____

Relationship of patient to card holder: ☐ Self ☐ Spouse ☐ Child

Please present your card to the pharmacist when getting prescriptions filled.

Would you prefer a child-resistant cap on your prescription vials? ☐ Yes ☐ No