New Patient Information Form

Patient's Name: ___________________________________ **DOB:** ________________

Phone: _________________________ **Email:** ________________________________

Address:

____

Street **City** **Zip**

Drug Allergies: ______________________ **Driver's License Number:** ______________

People authorized to pick up your prescription(s): ______________________________

I may be contacted about my prescription(s) via:

Phone ☐ **Voice mail** ☐ **Text message** ☐ **Mail** ☐ **E-mail** ☐ **Fax** ☐

Caps: ☐ **Easy Open** ☐ **Child Resistant**

Insurance Information

Insurance Provider: ____

Name on Card: ____

BIN: ___________________________ **PCN:** _________________________________

ID Number: _____________________ **Group Number:** _________________________

Granbury Drug & Compounding Privacy Practice Notice / HIPAA STATEMENT: By signing this document you acknowledge that you have read and understand your rights regarding your health information. This form authorizes the pharmacy to store and share your private health information with other health professionals or insurance companies.

Signature: ____________________________________ **Date:** ___________________