PLEASE PRINT - **If you have prescription insurance please present card with this form.**

Name:_____Sex: M F

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:(_____)_____ Cell:(_____)_____ Date of Birth:_____

SSN: _____ Drivers License No. & State: _____

Height: _____ Weight: _____ E-mail Address: _____

Please circle correct answer (where applicable)

Pregnant: Yes No Nursing: Yes No Smoker: Yes No

Do you have any drug allergies? Yes No

If yes, please list:_____

Are you taking any other medications? Supplements? Yes No

If yes, please list:_____

_____

Do you have any chronic health conditions or drug idiosyncrasies? If yes, please list.

High Cholesterol: Yes No High Blood Pressure: Yes No Depression/Anxiety: Yes No

Thyroid: Yes No Asthma: Yes No HIV: Yes No Diabetes: Yes No

Other:_____

Circle Preference: child resistant lids easy open lids Sign:_____

Lopez Island Pharmacy Patient Notification Form

Use this form to tell us who is involved in your care, so that we may provide them with the information they need to assist you. We will act upon the information you provide on this form unless you inform us that it has changed. This form does not apply in the hospital setting.

Circle Choice

Yes **No** You may leave messages at my home, or on my telephone, or cell phone regarding my health care.

Yes **No** You may E-mail me a recap or my appointment and care plan.

Yes **No** You may speak to family members or friends regarding my health care.

The individuals listed below are involved in my ongoing care. Lopez Island Pharmacists and staff may provide them with limited information about my condition and care as needed to assist me. I understand that information specific to drug and alcohol treatment, psychiatric conditions, and HIV/AIDS may be included.

Family Member/Friend	Relationship	Contact Number

Other Information

Do you have a Living Will? □ Yes □ No

Do you have Power of Attorney? □ Yes □ No

Power of Attorney name? _____

I am satisfied with the explanation regarding this form that I requested and received.

_____

Signature of patient or person authorized to sign for patient Relationship Date Time