HERITAGE PHARMACY INTAKE FORM

PHONE: 1-877-816-0942, FAX: 1-877-553-7372

(Please Print) (Pages 1 through 3 return to Heritage) (Pages 4 through 7 remain with the patient)

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Sex:** ❑ Male ❑ Female	**Birth Date:** / /
Street address:		**Social Security :**		**Phone:** ____________ **Cell** :
Emergency Name/Phone:	**City:**		**State:**	**ZIP Code:**

Allergies (Check all that apply): ❑ No Known Drug Allergies ❑ Erythromycin ❑ Tetracycline ❑ Penicillin ❑ Aspirin ❑ Codeine

❑ Sulfa ❑ Other (Please Specify) ____

Referred to pharmacy by (please check one box):	❑ Physician ❑ Facility ❑ Family	❑ Home Health Agency ❑ Friend ❑ Hospital ❑ Other______________
Name of Referring Party		

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes (Please send copy of insurance card, front and back to Heritage) ❑ No(Skip section)

Prescription insurance company:			Insurance Phone #
BIN #	PCN #	ID #	Group #
Cardholder's name	SS#		Birth date

Patient's relationship to Cardholder: ❑ Self ❑ Spouse ❑ Child ❑ Other____

ACKNOWLEDGMENTS AND RESPONSIBILITIES

Acknowledgment of Receipt of the Notice of Privacy Practice

______ I have received a copy of Heritage Pharmacy Notice of Privacy Practices. Federal regulations require that we obtain proof
Initial that our customers have received the Notice of Privacy Practice.

Notice of Non-Child Resistant Packaging

______ The Heritage Pharmacy strips and dispenser are NOT child resistant. By initialing, you indicate that you are requesting that all
Initial medications shall be dispensed in a "non-childproof" container.

Packaging Responsibilities

______ I understand that receiving this special packaging requires me to be involved in managing my medications. I will notify pharmacy of any
Initial medication changes as soon as possible, and will work with pharmacy to ensure I receive my medications on time.

RESPONSIBLE PARTY / CAREGIVER INFORMATION

Responsible Party/Caregiver is an individual who is helping to manage health care and/or finances for a patient. They are also involved in making decisions and/or payments for the patient.

Responsible Party/Caregiver's Name	Relationship to patient	Home (Cell) phone # ( )	Work phone # ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Heritage Pharmacy. I understand that I am financially responsible for any balance. I also authorize Heritage Pharmacy or insurance company to release any information required to process my claim

*Responsible party/Caregiver Signature*________________________________ *Date*______________

HERITAGE PHARMACY MEDICATION LISTING

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Medication Name & Strength – indicate name and strength of each medication taken
Directions – indicate how many and how often you take the medication
Qty On Hand-Date-Time- count number of doses left in medication container and record the time and date of the count
Administration Time – place an X in the column that matches when you take the medication

Patient Name:______________________________________Date of Birth: __________

Medication Name & Strength	Directions	Qty. On Hand-Date-Time	Morning	Noon	Evening	Bedtime
Example: *Ibuprofen 800mg*	*1 three times daily*	*12-4/26/12-2 pm*	*X*		X	X

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Patient Name:____Date of Birth: __________

Medication Name & Strength	Physician First & Last Name	Physician Phone	Prescription #	Pharmacy Phone
Example: *Ibuprofen 800mg*	*Dr. John Smith*	*614-567-4456*	12334-44568	614-345-8876