HERITAGE PHARMACY INTAKE FORM

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

(Return pages 1-3 to the pharmacy, pages 4-6 stay with the patient)

PATIENT INFORMATION (PLEASE PRINT)

Patient's Last name:	**First**	**Middle**	**Sex:** ☐ Male ☐ Female	**Birth Date:** / /
Street Address:		**Social Security:**		**Phone:** **Cell:**
City:	**State:**	**Zip Code:**	**Emergency Contact Name & Phone:**	

Allergies: (Check all that apply) ☐ No Known Drug Allergies ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Other(Please specify)____

Diagnoses:____

PRIMARY INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes (please send a copy, front and back, of the patients insurance card(s) ☐ No (skip section)

Cardholders Name:		**Insurance Company:**	
BIN#	**PCN#**	**ID#**	**Group#**

Patient relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other_______________________________________

SECONDARY INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes (please send a copy, front and back, of the patients insurance card(s) ☐ No (skip section)

Cardholders Name:		**Insurance Company:**	
BIN#	**PCN#**	**ID#**	**Group#**

PAYEE INFORMATION

Responsible Party/Caregiver who is in charge of patient's finances:

Name:	**Address**:	**Phone Number:**

MEDICATIONS/ MEDICAL SUPPLIES DELIVERY INFORMATION

Address for deliveries: ☐ Home ☐ Office ☐ Other (please specify)____________________________________

Do we have permission to leave the package if someone is not there to sign for it? ☐ **Yes** ☐ **No**

Medication Administration Records (MARs): ☐ Send monthly with medications ☐ Send monthly on ________________(date) ☐ Not Needed

ACKNOWLEDGMENTS AND RESPONSIBILITIES

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

_______ **Initials** The Heritage Pharmacy packaging is NOT child resistant. By initialing, you indicate that you are requesting that all medications shall be dispensed in "non-childproof" packaging.

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

RESPONSIBLE PARTY / CAREGIVER INFORMATION

Responsible party/ caregiver is an individual who is helping to manage healthcare and/or finances for a patient. They are also involved in making decisions and/ or payments for the patient.

Responsible party/caregivers name:	**Relationship to patient:**

Phone Number: Work:
Cell:

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:

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HERITAGE PHARMACY

PHYSICIAN AND PREVIOUS PHARMACY INFORMATION

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

Patient Name: ______________________________________ DOB:________________

(Please attach a *signed* copy of the patients physician's order sheet to this form)

Medication Name and Strength	Physicians Name (First and Last)	Physician's Phone Number	Prescription Number	Pharmacy Phone
Example: Ibuprofen 200mg	Dr. John Smith	(614)-567-4456	12345	(614)-345-8876

Medication Name & Strength - Indicate name and strength of each medication taken
Physician First & Last Name - Indicate the prescribing physician's first and last name
Physician Phone - Indicate prescription refill number listed on the prescription container from the previous pharmacy filling
Pharmacy Phone - Indicate the pharmacy phone number listed on the prescription container from the previous pharmacy filling

HERITAGE PHARMACY

MEDICATION LISTING & PILL COUNT

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

Patient Name: ____ DOB:__________________

(Please attach a *signed* copy of the patients physician's order sheet to this form)

Medication Name and Strength	Directions	Quantity on Hand-Date	Administration Times	Diagnosis
Example: Ibuprofen 200mg	1 Tab Daily	21 Tabs – 9/1/16	07:00 AM	Arthritis

Medication Name & Strength - Indicate name and strength of each medication taken
Directions - Inidicate how many and how often each medication is taken
Quantity On Hand-Date - Count Number of doses left in medication container and record that along with the current date
Administration Time - Indicate at what time or times each medication is administered
Diagnosis -Provevide the diagnosis for which the medication is treating