

# PATIENT INFORMATION SHEET

## Patient Information:

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Home: \_\_\_\_\_

## Text Messaging:

( ) Check if you would prefer to be contacted by text message when your prescription is ready and/or other necessary information needed to process your prescription. Please Initial: \_\_\_\_\_

## Additional Information

### REQUIRED:

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Date: \_\_\_\_\_ Gender: \_\_\_ M \_\_\_ F  
 Child  Pet Child or Pet's weight (required): \_\_\_\_\_ Caregiver name (if applicable): \_\_\_\_\_

( ) Check if you would like to be added to our patient email database to receive information about seminars, sales, health related updates and newsletters.

### Allergies:

Food: \_\_\_\_\_  
\_\_\_\_\_

Drugs: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Current Medications/Supplements: \_\_\_\_\_  
\_\_\_\_\_

Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Since health information may change periodically, please notify one of our pharmacists of any new medications (prescribed and non-prescribed), allergies, drug reactions or health conditions.

Your signature acknowledges your receipt of Rx3 Pharmacy's Notice of Privacy Practices according to Federal HIPAA Regulations (this notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your protected health information. Rx3 Pharmacy does NOT sell ANY patient information for any reason what so ever. Should you have any questions regarding HIPAA or Privacy Practices, please contact us at 804-717-5000 and ask for a pharmacist.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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