Cresco Family Pharmacy

PATIENT MEDICATION PROFILE

To help ensure that our patient records are accurate and up-to-date, please complete this form and return it to the Pharmacy for processing. This information is vital for prescription processing and will remain strictly confidential under HIPAA regulations.

Thank you for choosing Cresco Family Pharmacy!

Last Name_____First _____M.I._____

Street/Apt. No _____

City_____State_____ Zip Code _____

Telephone (_____)_____ Date of Birth_____ Sex ☐ Male ☐ Female

Medications currently taking _____

_____

Prescription Insurance Information BIN _____ GROUP_____ PCN _____

Member ID _____ Cardholder name _____

DRUG ALLERGIES List all that apply _____

Transfer all valid prescriptions? ☐ Yes ☐ No Pharmacy transferring from _____

Transfer for all members of your family? ☐ Yes ☐ No Pharmacy phone number _____

List names/dates of birth/allergies/insurance information for family members (use back of form if needed)

_____

_____

Would you prefer a non-child resistant cap on your prescription vials? ☐ Yes ☐ No

Would you like more information on our Prescription Club? ☐ Yes ☐ No

Would you like more information on our medication synchronization program? ☐ Yes ☐ No

Would you like more information on Dispill medication packaging? ☐ Yes ☐ No

Patient or guardian signature _____ **DATE** _____