First Name_____Middle Initial___

Last Name_____

Cell Phone_____

Email address_____

Ethnicity (circle one) 1) Non-Hispanic 2) Hispanic 3) Refused to Report

Primary Race (circle one) 1) White 2) Hispanic 3) African American or Black 4) Asian
5) Native American 6) Native Hawaiian 7) Other Pacific Islander
8) Other Race 9) Unreported/Refused to Report

Language 1) English 2) Spanish 3) Other_____

Current Medications:

	Name	Dose	Frequency	Reason Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Allergies:_____
_____

Pharmacy of Choice:

Name	Street Address	City	State	Phone Number	Mail Order?
					Y/N
					Y/N

Electronic Prescriptions:

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

Signature:_____ Date_____