CHANCY DRUGS
Est 1966

Welcome

To help us serve you better, please take a couple of **minutes to fill out the following information.**

New Patient _____ Existing Patient ____

PATIENT INFORMATION

Name _____ DOB _____

Address _____ Age _____

City, State, Zip _____ Sex M _____ F _____

Phone(s): Home _____ cell _____ work _____

Email _____

Drug Allergies _____

Please mark our special services you would like to receive:

____ Text message when Rx(s) is ready
____ Email message when Rx(s) is ready
____ Safety caps on your medications ***We recommend safety caps if you have small children in your home***

OTHER FAMILY MEMBERS AT HOME

Spouse/Parents _____ DOB _____ M ___ F ___

Child _____ DOB _____ M ___ F ___

Child _____ DOB _____ M ___ F ___

Child _____ DOB _____ M ___ F ___

Child _____ DOB _____ M ___ F ___

BILLING INFORMATION Please provide a copy of your current insurance card for our files. We understand that your insurance may change on occasion; a copy of your card will allow prompt billing for your medication.

HIPAA Due to the new Health Insurance Portability of Accountability Act (HIPAA), we must have your authorization in order to release your records or prescriptions to someone other than yourself. I have read and understand the Health Insurance Portability of Accountability Act (HIPAA).

SIGNATURE _____ DATE _____

(Guardian signature if patient is under age 18)