Sixth Avenue MEDICAL PHARMACY

Your trusted neighborhood pharmacy since 1964

New Patient Intake Form

Name:_____**Date of Birth**:_____

Address:_____

City:_____**State**: _____**Zip**: _____

Driver's License:_____E-Mail:_____

Cell Phone: _____**Day Phone**:_____

Would you like to receive text message or email notifications that your prescriptions are ready? Yes☐No☐

Do we have your permission to mail or deliver your prescriptions upon request? Yes☐No☐

Would you like to receive your medications with a NON-Safety cap (easy open)? Yes☐No☐

Would you like to enroll in our Simplify My Meds (sync) program? Yes☐No☐

Insurance:_____ID:_____

RX Group:_____ BIN:_____ PCN:_____ Phone #_____

SSN:_____

Allergies:_____

Chronic Conditions: High Blood Pressure High Cholesterol Diabetes

Thyroid Disorder

Other Chronic Condition(s):_____

Please list over the counter medications (including supplements) you take each day:

_____

_____

_____

I acknowledge of receipt of Sixth Avenue Medical Pharmacy's Notice of Privacy Practices

Signature:_____**Date**:_____

Thank you so much for your time! The Sixth Avenue Medical Pharmacy Staff (5-17)