Patient Information Form

Patient Name:	Birthday: _______/______/___________	Gender – please circle M F
Address:	City, State, Zip ____________,______,__________	Phone: ________-________-_________
Email:	Text messaging alerts: Yes ______ No________	If text elected, please list provider (Verizon, ATT, etc)
Allergies/Medical Conditions:		
2nd Patient Name – Same Address/Phone Number	Birthday: _______/______/___________	Gender – please circle M F
Allergies/Medical Conditions:		
3rd Patient Name – Same Address/Phone Number	Birthday: _______/______/___________	Gender – please circle M F
Allergies/Medical Conditions:		
4th Patient Name – Same Address/Phone Number	Birthday: _______/______/___________	Gender – please circle M F
Allergies/Medical Conditions:		

******If you have prescription insurance, please present your insurance card to a staff member******

I prefer non child-resistant caps on the prescriptions for the following members listed:

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I understand that my choice may result in an increased risk of dangerous medication exposure to children and pets and agree to hold Lake Murray Drug Company and its staff harmless for any such exposure.

I acknowledge that I have received, reviewed, and understand Lake Murray Drug Company's Notice of Privacy Practices (HIPAA).

Patient signature Date

Parent or guardian signature Date