ISLAND DRUG Service Excellence Delivered Locally
www.islanddrug.com

Pharmacy Intake Form

Welcome to Island Drug! Please complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

_____ _____/_____/_____

First Name M.I. Last Name ☐M or ☐F Date of Birth (MM/DD/YYYY)

_____ _____

Street Address (PO Box acceptable if given with physical address) City

_____ _____ (____)_____ (____)_____

State Zip Code Home Phone Cell or Work Phone *(Please Circle One)*

Weight (*required for children) _____ pounds Email Address_____

ALLERGIES: ☐No Known Allergies ☐Penicillin ☐Sulfa ☐Codeine ☐Aspirin ☐Erythromycin ☐Peanuts
☐Other: _____

CURRENT OVER-THE-COUNTER/HERBAL PRODUCTS:

_____

CURRENT MEDICAL CONDITIONS: ☐High Blood Pressure ☐Diabetes (Type I) ☐Diabetes (Type II)
☐High Cholesterol ☐Asthma ☐Epilepsy ☐Arthritis ☐Depression ☐Headaches ☐Glaucoma ☐Smoking:
☐Pregnancy (Due: _____) ☐Breastfeeding ☐No Known Medical Conditions
☐OTHER: _____

CHILD RESISTANT PACKAGING:

I request to have my prescriptions dispensed in ☐CHILD RESISTANT *or* ☐EASY OPEN caps. I also received the Notice of Privacy Practices.

_____ _____

Signature Date (MM/DD/YYYY)

INSURANCE: ☐No ☐Yes _____ _____

Name of Carrier Relationship to Cardholder

Space below reserved for copy of insurance card