GAUGHN'S DRUG STORE

New Patient Profile

Please Print All Information

Name: _____

Phone Number: (_____) _____-_____

Address: _____

Date of Birth: _____/_____/_____

_____

Email: _____

City/State/Zip: _____

Emergency Contact Name & Number :

Do you have any drug allergies? ____Yes ____ No

_____ (_____)

If Yes, please list: _____

Would you like safety caps on your medication? _____ Yes _____ No

_____

Were you referred to Gaughn's by a friend or family member? _____Yes ____ No

If Yes, please provide their name: _____

If you were not referred by a friend or family member, how did you hear about us?

_____

***If you have prescription insurance coverage, please present your insurance card.

Please list any medications you are currently taking that you did not obtain from Gaughn's Drug Store. _____

By signing below, I indicate that I have received a copy of the Gaughn's Drug Store Privacy Rules of Personal Health Information and H.I.P.A.A. regulations and all information given above is true to the best of my knowledge.

_____ _____

Patient Signature Date

If you would like to utilize our **FREE DELIVERY SERVICE** now or in the future, please complete the following:

I, _____, authorize Gaughn's Drug Store to release my medication to the following address _____ in the event personal contact cannot be made. My order may be placed: _____(ex: between screen & front doors, in mailbox, etc).

_____ _____

Patient Signature Date