AUBURN UNIVERSITY EMPLOYEE PHARMACY

NEW PATIENT FORM

PATIENT INFORMATION

Last name:	**First name:**	**MI:**	**Birth date:**	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Home Phone:** ( )

City:	**State:**	**ZIP Code:**	**Preferred Contact:** ❑ Home ❑ Cell ❑ Office	**Cell Phone:** ( )

Campus Address: *(Office number and building name)*	**Office Phone:** ( )

Delivery Location: ❑ AU Main Campus ❑ AUM ❑ Mail Order (>50 miles from campus)	**E-mail address:**

Insurance Contract Number:	**Group ID:**	❑ Cardholder ❑ Spouse ❑ Child	**Would you like easy-open tops?** *(these will not be child-proof)* ❑ Yes ❑ No

Would you like our pharmacy staff to synchronize your medications to fill at the same time every month?

❑ Yes ❑ No ❑ Would like more information

MEDICATION INFORMATION

Are you allergic to any medications? ❑ Yes ❑ No (If yes, list medications and reactions below):

Medication Name or Drug Class	**Description of what happened when you took this medication** *(i.e. difficulty breathing, hives, upset stomach, etc.)*

Current Pharmacy Name:	**Current Pharmacy Address:**	**Current Pharmacy Phone Number:**

LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING:

(include those taken daily or only as needed as well as any non-prescription medications and vitamins)

Prescription Number	**Medication Name**	**Dose/Strength** *(mg, etc.)*	**How do you take this?** *(How many times a day, time of day))*	**The reason you take this** *(high blood pressure, depression, diabetes, etc.)*

We will contact your current pharmacy to transfer any active prescriptions that they have for you to the AU Employee Pharmacy.

Please allow up to 48 hours for your prescriptions to be transferred.

The information provided on this form will be reviewed by healthcare providers in our Pharmaceutical Care Clinic.