AUBURN UNIVERSITY STUDENT PHARMACY

NEW PATIENT FORM

PATIENT INFORMATION

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

Home street address:	Cell Phone: ( )

City:	State:	ZIP Code:	Preferred Contact: ❑ Cell ❑ Alternative	Alternative Phone: ( )

Campus dorm or local address:

Banner ID:	Auburn e-mail address:

Are you a VCOM student (College of Osteopathic Medicine)?

❑ Yes ❑ No

Please attach a copy of your ***prescription*** **insurance card** (this is often a different card than your medical insurance)

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.)*

Would you like the pharmacy staff to transfer any active prescriptions from your previous pharmacy to the AU Student Pharmacy?❑ Yes ❑ No

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

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