

LaVergne Drug Store

Patient Medical Records

Date _____

Receive our FREE Monthly Newsletter via email? Y / N

Would you like to join our FREE Vitamin Program? Y / N

If yes, choose **ONE**: ___ Chewable ___ Tablet ___ Liquid ___ Calcium

How did you hear about us? _____

Patient Name _____ Sex _____

Phone _____ Fax _____ Cell _____

Birth ___/___/___ Wt _____ Ht _____

Address _____

City _____ State _____ Zip _____

E-mail _____

Driver's License _____ SS# _____

Allergies _____

Pregnant Y / N Breast Feeding Y / N Smoker Y / N

Diagnosis _____

Current Medicines _____

Child Safety Caps Y / N Auto Refill Y/N

I hereby acknowledge receipt of the Pharmacy Notice of Privacy Practices (HIPPA) indicated by the signature below.

Patient Signature

Parent, Custodial Parent or Legal Guardian Signature