Brookshire Brothers PHARMACY

PATIENT PROFILE

Patient Name: _____ /_____ /_____ Date of Birth: ____/____/____
Last First MI

Address: _____ Male ____ Female ____
Street

_____/_____/_____
City State Zip

Phone: (_____)_____ *Please check*: ☐ Home ☐ Cell ☐ Work
By providing your telephone number, you agree to receive pickup notifications, refill reminders, vaccine information, and other pharmacy-related information via automated calls or texts.

How would you like to be notified when your prescription is ready? ☐ Phone ☐ Text ☐ Email

Email: _____

Would you like your maintenance medications auto-refilled? Yes ____ No ____
(This option is not available for Medicaid, Medicare Part B, or controlled prescriptions).

Do you have a prescription insurance card? Yes ___ No ___ **If Yes, please present card.**

Would you like an easy open top on your prescription? *(**INDICATE WITH INITIALS**)* Yes ___ No ___
This is not an option for children's prescriptions. By indicating yes with your initials you accept liability for any children in your household. Anyone with children in their household should specify no on this question.

Are you allergic to anything? (Please Check Below) ☐ No Known Allergies

☐ Aspirin ☐ Tetracyclines
☐ Penicillin ☐ Sulfa Drugs
☐ Cephalosporins ☐ Codeine
☐ Erythromycin ☐ Other Please specify _____

Please list any non-prescription products you are currently using.

_____
_____

Please list any prescription drug you are currently using not purchased from this pharmacy.

_____
_____

What health conditions currently affect you?

_____
_____

_____ _____
Signature Date

Accepted by: _____