WinklesPharmacy
Building a Tradition of Trust

WWW.WINKLES-PHARMACY.COM

NAME:_____ **DOB (MM/DD/YYYY):**_____

ADDRESS:_____**ZIP CODE:**_____

HOME PHONE:_____ **WORK:**_____ **CELL:**_____

EMAIL:_____ **EMPLOYER:**_____

PERSONAL PHYSICIAN:_____ **PHONE #:**_____

EMERGENCY CONTACT:_____**PHONE#**_____

RELATIONSHIP:_____

IF YOU HAVE INSURANCE PLEASE PRESENT COPY OF CURRENT INSURANCE CARD

***IF UNDER 18, PARENT/GUARDIANS NAME:**_____

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of treatment. All information will be kept strictly confidential.

1. **Are you under the care of a physician? If so, for what condition?**

   _____

2. **Are you taking any current medication (including otc)?**

   _____

3. **Are you allergic to any medication? Please list.**

   _____

4. **Are you currently using another pharmacy? If so, would you like us to transfer your RXs?**

   _____

5. **Have you had adverse reactions to any drug, local anaesthesia, antibiotics, barbiturates, sedatives or pain killers?**_____

6. **Circle any of the following that you have had:**

Heart trouble	**Asthma**	**Blood disorder**	**Nervous disorder**
Cough	**Diabetes**	**Arthritis**	**Fainting spells**
Heart murmurs	**Anemia**	**Stroke**	**Rheumatic fever**
Hepatitis	**Jaundice**	**Congenital heart lesions**	**Sinus trouble**
Tuberculosis	**Epilepsy**	**High blood pressure**	**Other:** _____

7. **Are you pregnant or nursing?** _____
8. **How did you find out about our office?** _____
9. **Do you require prescription delivery?**_____

ANY INFORMATION YOU SHARE WITH WINKLES PHARMACY IS PERSONAL AND CONFIDENTIAL AND WILL NOT BE SHARED WITH ANYONE OR ANY OTHER BUSINESS. YOUR INFORMATION SHALL ONLY BE USED FOR INFORMATIONAL PURPOSES AND SHALL BE FILED AND OR DISCARDED IN COMPLIANCE WITH ALL STATE AND FEDERAL PRIVACY LAWS.

Please ask the technician for a copy of our privacy policies and HIPAA statement.