

Date:

Fifth and Browne Pharmacy

Patient Information Sheet

We must have this form signed and returned to us pursuant to new Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please fill out the following to set you up in our computer (or update our records), and to assure you the best service and treatment possible.

Personal Information:

Name:	Male:	Female:
Address:		
City:	State:	Zip:
Phone (home):	Phone (other):	
Date of Birth:		

Medical Conditions:

Please list any conditions or diseases that you are currently being treated for:

1.	4.
2.	5.
3.	6.

Allergies:

_____ I have no known allergies.

_____ I have allergies to the following medications or foods:

1.	4.
2.	5.
3.	6.

I hereby authorize Fifth and Browne Pharmacy to dispense medications to me and I have been given notice of their Privacy Policy concerning the protection of my Protected Health Information (PHI)

Signed: _____ **Date:** _____
Patient