



KORU PHARMACY

NUTRITION | WELLNESS

New Patient Intake Form

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Driver's License: _____ E-Mail: _____

Cell Phone: _____ **Day Phone:** _____

Would you like **text message** or **email** notifications that your prescriptions are ready? Yes or No

***If yes, please circle your preference (**text** or **email**)*

Do we have your permission to mail or deliver your prescriptions upon request? Yes or No

Would you like your medications with an easy open lid or in bubble packs? Yes or No

Would you like to enroll in our medication synchronization program? Yes or No

Allergies: _____

Insurance: _____ ID: _____

RX Group: _____ BIN: _____ PCN: _____ Phone # _____

SSN: _____

Chronic Conditions: ___ Anxiety ___ Arthritis ___ Asthma ___ Cancer
 ___ Chronic Pain ___ Depression ___ Diabetes ___ Thyroid
 ___ High Blood Pressure ___ High Cholesterol
 ___ Menopause/Hormone Disorders ___ Seizure Disorder /Epilepsy

Other Chronic Condition(s): _____

Please list all medications you take regularly which are not on file at Koru Pharmacy. Use back of sheet if necessary.

I acknowledge receipt of Koru Pharmacy's Notice of Privacy Practices

Signature: _____ **Date:** _____

THANK YOU for your time and for choosing us as your pharmacy.

The information we obtain helps us evaluate your medications, side effects and interactions and provide you with the best, most efficient pharmacy care.