

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:**

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

**Medical Conditions:**

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

<b>1.</b>	<b>4.</b>
<b>2.</b>	<b>5.</b>
<b>3.</b>	<b>6.</b>

**Allergies:**

\_\_\_\_\_ I have no known allergies.

\_\_\_\_\_ I have allergies to the following medications or foods:

<b>1.</b>	<b>4.</b>
<b>2.</b>	<b>5.</b>
<b>3.</b>	<b>6.</b>

**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**