



NEW PATIENT INFORMATION FORM

Name: _____

Date of Birth: _____

Social Security Number or Drivers License Number*: _____

Mailing Address: _____ City: _____

Zip Code: _____ Telephone: _____

Parent/Guardian (if child) or Owner (if for a pet): _____

Medication Allergies (Mark all that apply):

____ No Allergies

____ Sulfa drugs (like Bactrim)

____ Penicillin or Penicillin-like drugs (Amoxicillin, Ampicillin, etc)

____ Codeine

____ Other: _____

Insurance Information:

BIN number: _____

PCN number: _____

Group number: _____

ID number: _____

* = Social Security Number or Drivers License Number is required to be reported to the state by all pharmacies in Kentucky when filling prescriptions for controlled substances.