## City Pharmacy of Elkton, Inc.

723 Bridge Street
Elkton, Maryland 21921
410 398-4383 • 800 728-4374

## PATIENT REGISTRATION AND HEALTH HISTORY FORM

## PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out each section.** It is important to know that you have carefully reviewed every area of this form. This information will be entered into the computer and will be used to create your personal healthcare record with us.

FIRST NAME	INITIAL	LAST	NAME		BIRTHDATE				
STREET ADDRESS			CITY	STATE	ZIP				
BIRTHDATE	HOME PHONE	# \	WORK PHONE	CELL/MOBILE #					
What is the best way to contact you if we have questions regarding your medication?									
Are you taking ANY kind of medication now?    No Yes If yes please list below.									
Medication Name			Dosage						
		·							

Are you allergic to any medications?		☐ No ☐ Ye	s If yes ple	ease list below.				
Medication Name		Type of Reaction						
INSURANCE PRIMARY INSURANCE COMPANY	<u> </u>							
Cardholder's name	Plan#	Group#	II	D#				
Insurance Co. or PBM Name	Pharmacy	Help Desk#	Bin#	PCN#				
SECONDARY INSURANCE COMPANY	(							
Cardholder's name	Plan#	Group#	ID#					
Insurance Co. or PBM Name	Pharmacy	Help Desk#	Bin#	PCN#				
ARE YOU A MEMBER OF APG CREDIT UNION, WXCY LOYAL LISTENERS CLUB, THE UNITED STATES ARMED FORCES, THE CLERGY, OR ARE YOU A CHRYSLER RETIREE?  No Yes If yes please list below.								
I hereby attest that the informat the best of my knowledge.	ion I have ç	iven is correc	t and com	nplete to				
PATIENT SIGNATURE:			DATE:	_				
PATIENT OR RESPONSIBLE PARTY	NAME:							

RELATIONSHIP TO PATIENT: