PATIENT INFORMATION FORM

KVH PHARMACY

First Name: _____ **M.I.** _____ **Last Name:** _____

Date of Birth: _____ **Sex:** ☐ **M** ☐ **F** (Biological)

Physical Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

☐ **Home** _____ ☐ **Cell** _____

(Please check a preferred method of contact/communication)

Does KVH Pharmacy have permission to leave a voicemail? ☐ Yes ☐ No

Allergies: _____

Name of your primary doctor or provider: _____

Chronic conditions (select all that apply):

☐ Hypertension	☐ Arthritis	☐ **Other:** _____
☐ Diabetes	☐ High Cholesterol	_____
☐ History of stroke	☐ Depression or anxiety	_____
☐ Atrial fibrillation	☐ Thyroid Disease	_____
☐ Asthma/COPD	☐ Seizures	_____

PRESCRIPTION REFILLS & NOTIFICATION

Would you like to sign up for text alerts? The texts can tell you when your medications are ready to be picked up, let you know if we are waiting on a refill authorization from your provider and other time-saving communications. ☐ **Yes** ☐ **No**

Would you like the medications you take on a regular basis filled automatically? You would receive a message letting you know they are ready. ☐ **Yes** ☐ **No**

PRESCRIPTION INSURANCE INFORMATION (Found on the front of your prescription benefit card).

If this is your first time at the KVH pharmacy please bring your prescription benefit card with you so we may be able to serve you as quickly as possible.

Name of insurance company: _____ **Member ID:** _____

RX Group: _____ **BIN:** _____ **PCN:** _____

Signature: _____ Date: _____