NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Patient Registration Form – Pharmacy

Patient Name: _____ **DOB**: _____

Preferred Pharmacy: ☐ Fairfax ☐ Richford ☐ St. Albans ☐ Swanton

Phone: (h):_____(c): _____ (w): _____

Mailing Address: _____

Physical Address: _____

Prescription Insurance Carrier: _____

BIN: _____ **PCN:** _____ **Grp:** _____

Member ID: _____ **Medicaid #:** _____ **Medicare #:** _____

MEDICATION ALLERGIES: *Please check all that apply and include reaction that occurs*

☐ None
☐ Aspirin _____
☐ Codeine _____
☐ Other: _____
☐ Penicillin _____
☐ Sulfa _____
☐ Erythromycin _____
☐ Other: _____

MEDICAL CONDITIONS: *please check all that apply*

☐ Arthritis
☐ Diabetes Type II
☐ Heart Disease
☐ Smoking
☐ Breast Feeding
☐ Asthma/COPD
☐ Epilepsy
☐ High Blood Pressure
☐ Thyroid Disorder
☐ Other: _____
☐ Depression
☐ Glaucoma
☐ High Cholesterol
☐ Pregnancy - Due Date: _____
☐ Diabetes Type I
☐ Headaches

CURRENT MEDICATIONS: *Please list all current medications, over the counter medications, vitamins, and supplements including the reason you are taking this medication, the dose and the frequency. Continue on back of page if necessary*

Medication 1: _____

Medication 2: _____

Medication 3: _____

CHILD RESISTENT PACKAGING:
I request to have my prescriptions dispensed in a ☐ Child Resistant Cap ***OR*** ☐ Easy Open Cap

SIGNATURE: _____ **Date**: _____

Relationship to Patient: ☐ Self Other: _____