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** ☐ **Yes** If yes please list below.

Medication Name	Type of Reaction

INSURANCE

PRIMARY INSURANCE COMPANY

Cardholder's name Plan# Group# ID#

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 information I have given is correct and complete to the best of my knowledge.

PATIENT SIGNATURE: DATE:

PATIENT OR RESPONSIBLE PARTY NAME:

RELATIONSHIP TO PATIENT: