

MCGLYNN PHARMACY INTAKE FORM

(Information is to be filled out for the person getting the prescription)

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Sex: Male Female

Drug Allergies: _____

Insurance: yes no – If yes, please present insurance card.

I would like non-safety (easy open) caps on my prescription bottles
(please initial): _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy or viewed a website copy on www.McGlynnRx.com of McGlynn Pharmacy’s Notice of Privacy Practices. This notice contains information regarding McGlynn Pharmacy’s use and disclosure of my personal health information. Since health information may change periodically, I will try to notify the pharmacist of any new medications, changes in directions of medications, new allergies, drug reactions, or health condition changes.

Signature: _____ Date: _____