New Patient Information Sheet

Full Patient Name: Last _________________________ First ______________________ MI _____

Home Address: ____

City _____________________________________ State ____________ Zip ____________________

Home Phone # ____________________________ Cell Phone # ______________________________

Email ___________________________________

Date of Birth ____________________________ Gender__________

Preferred Method of Contact?

Interested in talking to us to learn about our Automatic Refill Reminder Programs? (Y / N)

Medication Allergies: ____

Medical Conditions: ____

Special Requests (e.g. Easy Open Caps, Brand Name if Available, etc.): __________________________

Other Information: (e.g. New Mom, Vegan, etc.) ____

On File For Controlled Medications:

Driver's License # _____________________ DL State _____________ DL Expiration Date ____________

SSN: ______________________________

Insurance Information (if Applicable):

Prescription Insurance Plan Name ____

BIN# _____________________ PCN# _____________________ RX Group # ____________________

Card Holder ID# ____

Relationship of Patient to Cardholder: (e.g. Self, Spouse, Child) ________________________________

THANK YOU FOR BECOMING A VITAL PLUS PHARMACY CUSTOMER!