GLANDER PRESCRIPTION PLUS

Patient Information and Acknowledgement Form

Please complete the following information for our records

NAME_____
LAST FIRST MIDDLE

ADDRESS_____
STREET APT #/PO BOX CITY STATE ZIP

TELEPHONE# _____ DATE OF BIRTH _____ MALE FEMALE

SECONDARY#_____

PERSONAL MEDICATION INFORMATION

PLEASE LIST ALL DRUG, FOOD, OR CHEMICAL ALLERGIES AND ANY DRUG REACTIONS YOU MAY HAVE HAD:

PLEASE LIST ANY MEDICAL CONDITIONS WE SHOULD BE AWARE OF:

I acknowledge that I have received a copy of the Glander Prescription Plus Notice of Privacy Practices. This notice contains information regarding Glander's use and disclosure of my personal health information. Since health information may change periodically, I will notify the pharmacist of any new medications, changes in directions for medication use, new allergies, drug reactions, or health condition changes.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE