Bloomington Drug

Bloomington's First Pharmacy

For Office Use:

Clerk _____

Officer _____

Name _____
Last First Middle

Address _____
Street City State Zip

Telephone _____ Date of Birth _____
Home Cell

Email _____ Social Security # _____

Insurance _____
ID Rx Group Rx BIN Rx PCN

Sex MALE FEMALE

DRUG ALLERGIES

- ☐ No Known Allg _____
- ☐ Penicillin _____
- ☐ Cephalosporins _____
- ☐ Sulfa Drugs _____
- ☐ Erythromycin _____
- ☐ Tetracycline _____
- ☐ Quinalone _____
- ☐ Aspirin _____
- ☐ Anesthetics _____
- ☐ Codeine _____
- ☐ Morphine _____
- ☐ Meperidine _____
- ☐ Egg _____
- ☐ Peanut _____

Preferred Container:

☐ Child - resistant ☐ Easy Open

MEDICATION TRANSFER LIST

Previous Pharmacy _____

Pharmacy Phone # _____

Rx #	Drug Name

MEDICAL CONDITIONS

- ☐ No Chronic Medical Conditions
- ☐ Diabetes (250.00, 250.01)
- ☐ Asthma (493.2)
- ☐ Heart Disease (429.9)
- ☐ High Cholesterol (272.0)
- ☐ High Blood Pressure (401.9)
- ☐ Blood Clotting Disorder (286.3)
- ☐ Kidney Disease (588.9)
- ☐ Liver Disease (573.3)
- ☐ Stomach Ulcer (531.7)
- ☐ Anxiety (300.0)
- ☐ Arthritis (711.9)
- ☐ Headaches (784.0)
- ☐ Migraines (346.9)
- ☐ ADD/ADHD (314.00, 314.01)
- ☐ Are you pregnant or planning to become pregnant in the near future?

_____

I authorize the following people to pick up prescriptions:

_____

_____

_____

_____
signature date

I acknowledge that I've received a copy of Bloomington Drug's Notice of Privacy Practices. This notice contains information regarding Bloomington Drug'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, any drug reactions, and changes in health condition.

_____ _____
signature of patient/guardian date

Bloomington Drug

Bloomington's First Pharmacy

Please complete this form to begin receiving services from Bloomington Drug Pharmacy. This form can be returned to the pharmacy or faxed to 952-884-6366. Please contact us with any questions about this process or completing this form.

Resident's Name: _____ Date of Birth: _____

Billable Party Contact Info:

Billable Party Name: _____

Billing Address: _____

Phone Number: _____

Please choose one of the following options:

☐ **HOUSE CHARGE**

Each month you will receive a bill from Bloomington Drug. This bill is to be paid in full by the end of each month.

☐ **CREDIT CARD**

Each month the following credit card will be charged by Bloomington Drug during the first week for services received in the previous month.

Credit Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____ VIN #: _____

Phone Number: _____

I acknowledge that I have provided current insurance information to Bloomington Drug and I understand that I am responsible for all co-pays associated with my medication(s). I agree to pay Bloomington Drug any remaining balance of my account if I were to move out of this facility.

Signature: _____ Date: _____

If applicable, please include copies of the front page and the signature page of your Power of Attorney paperwork.

509 West 98th Street, Bloomington, MN 55420 phone 952-884-7528 fax 952-884-6366
www.bloomingtondrug.com