Simon-Williamson Clinic Pharmacy
Patient Medication History

To help ensure that our patient records are accurate and up-to-date, please complete this form and return it to the pharmacist for processing. This information is vital for prescription processing and will remain confidential.

Thank you for shopping at our pharmacy.

Please print. Use a separate sheet for each patient.

First Name: _____ M.I.: ____ Last Name: _____

☐ Male ☐ Female Birth Date _____

Social Security # _____

Street / Apt. # _____

City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Drug Allergies
Please check all that apply

☐ Aspirin ☐ Penicillins ☐ Other
☐ Codeine ☐ Tetracyclines Please Specify: _____

Do you have a prescription card that pays for prescriptions? ☐ Yes ☐ No

Name of Cardholder: _____

Relationship of patient to cardholder: ☐ Self ☐ Spouse ☐ Child

Please present your card to the pharmacist when getting prescriptions filled.

Rx BIN # _____ **Rx ID #** _____

Rx PCN # _____ **Rx Group #** _____

Would you prefer a child-resistant cap on your prescription vials? ☐ Yes ☐ No

Patient or Guardian Signature _____ Date _____