2026 Babcock Road, Suite # 104 • San Antonio- 78229, TX
Ph : 210.467.5174 • Fax: 210.467.5184
www.AssureRxPharmacy.com

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

NEW PATIENT FORM

Patient Information

Last Name: ____

First Name: ______________________ Middle Initial ______________

DOB: ________________ ☐ Male ☐ Female

Address ____

City ______________________ State __________ Zip ____________

Phone: ______________________ Mobile: ______________________

Last 4 Digits of SS# ________________

Medication and Food Allergies

ASPIRIN	SULFER	PENCILLIN	CODEINE	TETRACYCLINE
OTHERS:				

Do you object o the use of Child Resistant Caps .... ☐ yes ☐ No

Automatic Refills............ ☐ yes ☐ No

Would you like the Prescription instructions in Spanish............ ☐ yes ☐ No

Can anyoneelse pickup your Prescriptions............ ☐ yes ☐ No

If yes, their Name: ____

"FOR WOMEN OF CHILD BEARING AGE"

If you are Pregnant you are obliged to inform the Pharmacy............ ☐ yes ☐ No

Acknowledgement

I give permission to Assure Rx Pharmacy, to sign my name to logs for my medication(s) when my medication is mailed or deliered, I acknowledge receipt of pharmacy's notice of provacy practices for protected health information and refill authorization (HIPAA)

Patient's Signature: ______________________ **Date:**________________