
**MEMORIAL COMMUNITY PHARMACY**
**1900 State Street - Chester, IL 62233**
**618-826-6134**

# OUTPATIENT PHARMACY INTAKE FORM

Date: ___/___/_____

Patient Name: _____ DOB: ___/___/_____ ☐ ☐ **Male | Female**

Address: _____
Street City State Zip Code

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email: _____ Preferred Pickup: ☐ ☐ **Pharmacy | Kiosk**

Prescription Plan Name_____

RX BIN: _____ RX PCN: _____

***How would you like to be notified when your prescription is ready?*** ☐ ☐ **Email | Text**

***Would you like your prescription to be refilled automatically when they are due?*** ☐ ☐ **Yes | No**

**Note:** *Automatic fills are for maintenance medications only.*

**Allergies with Reaction:** _____

## Preferences

☐ Easy Open ☐ Visually Impaired ☐ Hearing Impaired ☐ Do Not Phone

**Please have your driver's license and insurance cards ready for pharmacy staff.**

**Signature:** _____