CANADIAN PHARMACY CHOICE

PATIENT PROFILE FORM

PATIENT INFORMATION:

Name: |_____|

Gender: | Male | Female | Date of Birth: | D | D | M | M | Y | Y | Y | Y |

DRUG ALLERGIES AND/OR MEDICAL CONDITIONS:

CURRENT MEDICATIONS:
(prescription and over-the-counter)

SHIPPING / MEMBER INFORMATION:

Name: |_____|
(If not Patient)

Address: |_____|

City: |_____| State: |___| Zip: |_____|

Day Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Evening Phone: |___|___|___| - |___|___|___| - |___|___|___|___|

Cell Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Fax: |___|___|___| - |___|___|___| - |___|___|___|___|

Email: _____

PHYSICIAN INFORMATION:

Name: |_____|

Office Address: |_____|

City: |_____| State: |___| Zip: |_____|

Day Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Evening Phone: |___|___|___| - |___|___|___| - |___|___|___|___|

Cell Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Fax: |___|___|___| - |___|___|___| - |___|___|___|___|

Email: _____

FAMILY AND CORPORATE PLAN INFORMATION:

Register this patient under the family plan of:

Member Name: |_____|

Register this patient under the corporate plan of:

Corporation: |_____|

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