DOVER FAMILY PHARMACY

Customer Profile

So that we may provide exceptional personalized pharmacy care, please complete this customer profile below and return it to the prescription drop off.

Please Print

Name (last, first, middle initial)

Date of Birth [- -][ ] Female [ ] Male

Street Address

City **State** **Zip**

Preferred Phone Number

Would you like our Fast Text option? [ ] Yes [ ] No

Cell Phone Number **Service Provider**

Would you like to be contacted by a MedSync Specialist to get your prescriptions filled all on the same day every month? [ ] Yes [ ] No

If you are allergic to any medications please list:

Have You Been Diagnosed with: (Please Circle)

Diabetes **Asthma** **COPD** **High Cholesterol**

High Blood Pressure **Immune Disorders** **Heart Disease**

Rheumatoid Arthritis **Glaucoma** **Neurological (seizures)**

Skin Disorders

Please List ALL Medication that you are currently taking on the back of this card.

Dover Family Pharmacy has requested this information from you to create a confidential customer record to be maintained at the pharmacy. For complete details, please reference our Notice of Privacy Practices, as required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA).