DINNO HEALTH **Date:_____**

New Prescription/Patient Intake Form

1. Patient Name:_____ DOB:_____

2. Parent/Guardian/Nurse
   Name:_____Relationship:_____

3. E-Mail Address:_____

4. Address:_____ Phone #:_____

   _____ Cell #:_____

   Alt #:_____

   Would you like us to contact you when you medication(s) are ready? ___YES ___ NO

   Preferred method: Phone call Text

5. **Medication Allergies and <u>your Reaction(s) to each</u>**:

   _____

   _____

   _____

   _____

6. Food Allergies/Diet Restrictions and **<u>your Reaction(s) to each</u>**:

   _____

   _____

   _____

7. Current Medication List **including OTC/herbal medications** (name of medication only):

   _____

   _____

   _____

8. Insurance Information:

   (Primary Insurance) (Secondary Insurance)

   a. Name:_____ Name:_____

   b. Rx BIN:_____ Rx BIN:_____

   c. Rx PCN:_____ Rx PCN:_____

   d. ID:_____ ID:_____

   e. Group:_____ Group:_____