

JEFFREYS DRUG STORE, INC

NEW PATIENT FORM

NAME	
BIRTHDATE	____ / ____ / ____
ADDRESS	
HOME PHONE	
CELL PHONE	
INSURANCE	
EMAIL ADDRESS	
DRUG ALLERGIES	

As detailed in our Notice of Privacy Practice, Jeffreys Drug Store will use and/or disclose your private health information for treatment, payment and health care operation.

You have been provided with and/or had a chance to review our Notice of Privacy Practices which provides examples of our uses and disclosures of your private information and your rights with respect to your health information.

We invite you to discuss any concerns regarding the privacy of your personal information with our Privacy Officer at any time.

I acknowledge that I have received and/or been given the chance to review the Notice of Privacy Practices from Jeffreys Drug Store.

Patient Signature

Date

If patient is unable to sign

Personal Representative Signature

Relationship

Date