Bates DRUG STORES, INC.
Bates Pharmacy & Medical Supply
Serving Spokane Since 1942
Employee Owned Since 2002

3704 N. Nevada
Spokane, WA 99207
(509) 489-4500

_____ _____ **Male/Female**
Name **Date of Birth**

Address **City** **State** **Zip Code**

_____ _____
Home Phone **Cell Phone** **Social Security Number**
Email Address_____

Primary Care Provider_____
Address/Phone

Allergies (Circle) No Known Allergies Aspirin Bee Stings Cephalexin Codeine Morphine Penicillin Seasonal Sulfa

Other_____

Health Conditions (please check all that apply & specify where indicated:

☐ AIDS/HIV ☐ Alcohol/Chemical Dependency_____ ☐ Allergies_____ ☐ Arthritis_____ ☐ Asthma_____ ☐ Back Condition_____ ☐ Bipolar ☐ Cancer_____ ☐ Cerebral Palsy ☐ Chemical/Fragrance Sensitivity_____ ☐ Chronic Fatigue ☐ Chronic Pain_____ ☐ Diabetes_____ ☐ Difficulty Concentrating ☐ Depression / Anxiety_____	☐ Epilepsy_____ ☐ Fatigue / Weakness ☐ Fibromyalgia ☐ Heat Sensitivity ☐ Heart Condition_____ ☐ Heat Sensitivity ☐ Hepatitis_____ ☐ Hyperglycemia ☐ Hypoglycemia ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Low Cholesterol ☐ Lupus ☐ Lyme Disease ☐ Migraines_____ ☐ Multiple Sclerosis ☐ Muscular Dystrophy	☐ Myasthenia Gravis ☐ Paranoia ☐ Parkinson's Disease ☐ Photosensitivity ☐ Respiratory Difficulties_____ ☐ Schizophrenia ☐ Seizure Activity_____ ☐ Skin Irritations ☐ Sleep Disorder_____ ☐ Smoker ☐ Speech Impairment_____ ☐ Stroke_____ ☐ Temperature Sensitivity ☐ Thyroid _____ ☐ Ulcer_____ ☐ Vision Impairment_____

☐ No Known Health Condition(s)

Other_____

_____

(Continued on back side)

List of current Medications, Strength & Directions (1)_____

(2)_____(3)_____

(4)_____(5)_____

(6)_____(7)_____

(8)_____ (9)_____

(10)_____(11)_____

Previous Pharmacy:_____
Address/Phone

- ☐ **I have no prescription drug coverage. Please provide the following if you have Insurance & copies of cards:**

Insurance _____
Name of Insurance **Group Number** **ID Number**

Cardholder_____YES or_____**Dependent/Spouse** **Medicaid**_____
Provider One Number

Medicare Number_____ **Name of Facility/AFH, if patient**_____

Private Pay Responsible Party_____
Name **Address** **Phone**

Do you require specialized packaging/services?

- ○ Free Delivery
- ○ Easy Open Lids
- ○ Blister (Bubble) Packaging
- ○ Weekly Medication Box
- ○ Automatic refills

Need Medical Supplies/Equipment?

Yes:_____
_____
_____
_____
_____

Any other special needs/requests?_____
_____
_____

Privacy Policy Acknowledgement: I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices (NOPP) of Bates Drug Stores, Inc. posted in the store, or have been given my own copy. ***HIPAA:*** I understand that Bates Drug Stores, Inc. through its HIPAA policies is obligated to protect my confidential personal health information. I have the right to request to see their HIPAA policies at any time.

Signature:_____

Date:_____