



1042

Patient 1 (Cardholder)

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□□ / □□ / □□□□

Date of Birth is required for patient identification.

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

Patient 2

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□□ / □□ / □□□□

DRUG ALLERGIES

List other Allergies here:

- No Known Allergies
- Acetaminophen/Tylenol®
- Amoxicillin
- Aspirin
- Cephalosporin (i.e., Keflex®, Cephalexin)
- Codeine
- Erythromycin, Biaxin®, Zithromax®
- NSAIDs (i.e., Ibuprofen, Naproxen)
- Oxycodone (i.e., OxyContin®, Percocet®)
- Penicillin
- Sulfa
- Tetracycline (i.e., Doxycycline, Minocycline)

List other Allergies here:

HEALTH CONDITIONS

List other Health Conditions here:

- No Known Health Conditions
- Arthritis (715.9)
- Asthma (493.9)
- Chronic Bronchitis or Emphysema (496)
- Depression (311)
- Diabetes Type I (250.01)
- Diabetes Type II (250.00)
- Epilepsy/Seizures (345.9)
- GERD (530.81)
- Glaucoma (365.9)
- High Cholesterol (272.9)
- Hormone Replacement Therapy (627.9)
- Hypertension (401.9)
- Thyroid: Low (244.9)

List other Health Conditions here:

OTC

List other OTC that you take on a regular basis:

- No Over-the-Counter Medications
- Acetaminophen/Tylenol®
- Advil®/Aleve®/Motrin®
- Aspirin/Excedrin®

List other OTC that you take on a regular basis:

DEVICES

List Medical Devices here:

- No Medical Devices
- Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.

List Medical Devices here:

OTHER

List other Prescription Medications here:

- No Other Prescriptions
- Prescription Medications not filled through Express Scripts Pharmacy.

List other Prescription Medications here:

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required _____