Confidential Patient Questionnaire

MAXOR PHARMACIES

Name: _____
Last *First* *MI*

Address: _____ E-mail: _____
Street *City* *State* *Zip*

Phone: _____ _____ Preferred Method of Contact: ☐ E-mail ☐ Reg. Mail ☐ Phone

Sex: ☐ M ☐ F ID #: _____ DOB: __ __ / __ __ / __ __ __ __ Primary Care Physician: _____
(DEERS, Insurance #)

Drug Allergies: ☐ None ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Other _____

Severity of Allergies: ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerance ☐ Anaphylaxis

Chronic Illnesses: (Chronic Disease States):

☐ Thyroid ☐ High Blood Pressure ☐ Diabetes ☐ Glaucoma

☐ Heart Condition ☐ Intestinal Disorders ☐ Lung Condition ☐ Other _____

Primary Insurance: _____ Name on Policy: _____

Group No: _____ Member No: _____

Secondary Insurance: _____ Name on Policy: _____

Group No: _____ Member No: _____

Consent for Use and Disclosure of Health Information

By signing this form, I consent to Maxor National Pharmacy Service Corporation's use and disclosure of my protected health information "PHI" and my contact information, for treatment, payment, and health care operations. I have been provided Maxor's Notice of Privacy Practices, which contains a more complete description of Maxor's use and disclosure of my PHI, and I understand that I have the right to review the Notice prior to signing this consent. I understand the Notice is subject to change, and I can obtain a current Notice contacting Carl Birdsong, Maxor's Privacy Officer. I understand that I have the right to request additional restrictions on the use and disclosure of my PHI, but that Maxor may not be required to accept the requested restrictions. I understand that if Maxor agrees to a requested restriction, the restriction is binding on Maxor. I understand that I must revoke this consent in writing, except to the extent that Maxor has relied upon it. I have read and understand this form. I understand that this information will be entered into Maxor's Pharmacy Computer Systems and will be accessed only by authorized professionals and para-professionals of Maxor.

I authorize Maxor National Pharmacy Services Corp. to act on my behalf in the fulfillment of pharmaceutical care. This includes:

- the receipt of prescriptions from my physician, or other health care provider;
- the intervention or interaction with my physician or other health care provider;
- the entering of information into Maxor's Pharmacy Computer System; and
- the interactions with my insurance company, health maintenance organization or other third-party payer.

I understand that Maxor National Pharmacy Services Corp. is obligated to collect all co-pays related to my pharmaceutical care.

Signature: _____ Date: _____
Customer, Guardian or Health Care Agent

A copy of the current Maxor Notice of Privacy Practice can be obtained through a written request to:

Carl Birdsong, R.Ph.
Maxor National Pharmacy Services Corp.
320 S. Polk Street, Amarillo, TX 79101
e-mail: privacy@maxor.com
Phone: (800) 658-6146
Fax: (806) 324-5495

Maxor Use Only:

Date Entered: _____

Entered by: _____

Please provide information regarding your medication history in the space below. This information assists Maxor Pharmacists in providing the best possible care.

Current Prescription Medications (Taken on a regular basis)

Name of Medication	Dosage and Directions

Current Over-the-Counter Medications

Name of Medication	Dosage and Directions

Medications no longer taken or not taken on a regular basis

Name of Medication	Reason medication was stopped