



#2 DEPENDENT INFORMATION

Name (First, Last)	
E-mail Address	
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (please do not use P.O. Box)	
City	State ZIP Code
Daytime Phone	Evening Phone
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline	
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):	
Dr. Name (print)	Dr. Phone (very important)
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.	

#3 DEPENDENT INFORMATION

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Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female	
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Please complete both pages of this form.