STARK PHARMACY:

NEW PATIENT INTAKE FORM:

PATIENT NAME:		
GENDER:		
ALLERGIES:		
LIST OF MEDICATIONS:		
DOB:		TEL:
ADDRESS:		
CITY:	STATE:	ZIP:

PRESCRIPTION PREFERENCES:

☐	PLEASE DO NOT SEND ME NOTIFICATIONS
☐	ARE YOU INTERESTED IN MAIL OR DELIVERY OPTIONS

PLEASE SEND ME NOTIFICATIONS

☐	EMAIL ADDRESS:
☐	CELL PHONE:
☐	HOME PHONE:
☐	OTHER:

I ACKNOWLEDGE RECEIPT OF STARK PHARMACY'S NOTICE OF PRIVACY PRACTICES. I HAVE READ AND UNDERSTAND THE NOTICE AND MY RIGHTS REGARDING THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION.

SIGNATURE: DATE:

Stark PHARMACY

5701 WEST 119TH STREET OVERLAND PARK, KS 66209• (913) 345-3800• starkpharmacy.com