Welcome to the UMass Memorial Prescription Center Pharmacy

Please complete the following form. Pharmacies are required to request this health care and demographic information from patients receiving prescriptions. Thank you for your cooperation.

Demographics

Last Name: _____ First Name: _____ Middle Initial: ____

Sex: _____ Date of Birth: _____ Social Security Number: _____

Street *(include apartment/unit/PO Box)*: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone *(include extension)*: _____

Current Medications

Please list all medications that you take. Include prescription medications, as well as over-the-counter medications and herbal supplements. Please update us regularly with each doctor's visit.

Medication Name and Strength	How Many	Frequency

Medication Allergies

1. _____
2. _____
3. _____
4. _____

Current Medical Conditions

1. _____
2. _____
3. _____
4. _____

A photocopy of your insurance card will be taken at the Prescription Center Pharmacy.

UMassMemorial
Prescription Center Pharmacy