





1 5 4 0 0 0 P R I O R P R Y 0 0 1

<input type="text"/> <input type="text"/> Print patient ID No. in boxes at left (if on ID card) <b>DEPENDENT INFORMATION</b>		
Name (First, Last)		
E-mail address		
<b>Date of Birth (MM/DD/YYYY)</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ( ) ( ) ( )	Evening Phone ( ) ( ) ( )	
<b>ALLERGIES:</b> <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		
<b>HEALTH CONDITIONS:</b> <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> No Known <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> Other (list):		
Dr. Name	Dr. Phone (very important) ( ) ( ) ( )	
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.		
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Please complete both pages of this form.