Auburn University Pharmacy Health Services

New Patient Form

NAME : _____
(Last, First, Middle)

GENDER ❑ Male ❑ Female

DATE OF BIRTH: _____

CAMPUS HALL & RM #, AUBURN OR OPELIKA ADDRESS ONLY:

Street (w/APT. No.) or P.O. Box_____

City_____ State_____ ZIP_____

TIGER CARD ID : 90_____

PHONE: (_____) _____-_____

VCOM STUDENT (Doctor of Osteopathy School) ❑ Yes ❑ No

ALLERGIES TO MEDICINE: ❑ Yes ❑ No
Please list if yes.

_____

If so, please describe the type of reaction:
_____

MEDICATIONS CURRENTLY TAKING:

Please provide insurance information when you present or fax this form. You may fax photocopy of insurance cards, etc.