GEM Rx
Edwards Pharmacy™
A GEMCORE™ FAMILY COMPANY

YOUR TRUSTED COMPOUNDING PHARMACY

NEW PATIENT MEDICATION ENROLLMENT FORM

(Please complete all fields)

Patient Information

First Name: _____ Last Name: _____ DOB: __ /__ /____ ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Preferred Method: ☐ Home ☐ Cell

E-Mail Address: _____

Known Drug Allergies: ☐ Yes ☐ No Explain: _____

Employer: _____ Employer Phone: _____

Physicians

Primary Care Physician _____ Primary Care Office Phone: _____

Primary Care Physician Location: City: _____ State: _____

Other Physician _____ Office Phone: _____

Other Physician Location: City: _____ State: _____

Current Health Conditions *(Please check all that apply)*

☐ ADHD	☐ Cardiovascular Disease	☐ Heartburn	☐ Osteoporosis
☐ AFib	☐ Chest Pain	☐ Hepatitis	☐ Pain
☐ Alcohol / Drug Dependency	☐ Constipation	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Allergies	☐ COPD	☐ High Cholesterol	☐ Psoriasis
☐ Anemia	☐ Depression	☐ HIV / AIDS	☐ Restless Leg Syndrome
☐ Anxiety	☐ Diabetes	☐ Inflammatory Bowel Disease (IBD)	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Enlarged Prostate	☐ Irritable Bowel Syndrome (IBS)	☐ Schizophrenia
☐ Asthma	☐ Fluid Retention	☐ Kidney Disease	☐ Seizures
☐ Autoimmune Disorder	☐ Gastrointestinal Disorder	☐ Lung Disease	☐ Sexual Dysfunction
☐ Bipolar Disorder	☐ Glaucoma	☐ Migraine Headache	☐ Sleep Disorder
☐ Bladder Control	☐ Gout	☐ Mood Disorder	☐ Stroke
☐ Blood Clot Prevention	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Cancer	☐ Heart Failure	☐ Nerve Pain	☐ Other

☐ Other: _____

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Medication Profile:

Name / Strength	Prescriber	Directions Quantity I Form I Route I Frequency	Potential Problems Indication I Efficacy I Safety I Adherence I Cost

Current Pharmacy:

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

Refills remaining on prescriptions?: ☐ Yes ☐ No

If yes, list medications: _____

Other:

Would you like to receive prescription notifications?: ☐ Yes ☐ No Notification Method: ☐ Call ☐ Text ☐ Email

Do you want your prescriptions to be refilled automatically?: ☐ Yes ☐ No

What is your desired initial medication delivery date: _____

Additional Notes: _____

_____

_____