PATIENT & PHARMACY INFORMATION

Please fill out the top portion of this form, so that we may have verification of your essential information.

Also, we have a required computerized prescription program that improves accuracy, security and convenience in prescribing medications. This program electronically transmits most of your prescriptions directly to the pharmacy of your choice and significantly reduces waiting time. In some cases, we can even transmit your prescriptions to mail order pharmacies.

We need to obtain information on your preference of pharmacies. Please designate a primary pharmacy. Also, if you have a mail order benefit program, select the appropriate box below.

We understand that you may not have all your information with you today; however, please complete the following to the best of your ability.

Today's Date _____ Social Security Number ___-___-___ ___-___ ___-___-___-___

Patient Name _____ DOB _____
(*Please print)*

Street Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Primary Care or Referring Physician _____
(First and Last Name)

Phone _____ FAX _____

Pharmacy Information

Name *(ex. CVS, Rite Aid)* _____ Address _____

City _____ State _____ Zip _____ Phone _____

Mail Order □ Medco □ Express Scripts, Inc. □ Other _____
□ CareMark □ PharmaCare

Drug Allergies

Please list all of your drug allergies: _____

_____