Patient Pharmacy Policy:

Please complete the information below for our Physicians and Providers to electronically or by telephone, prescribe medications for you. We prefer to prescribe medications via our Medent electronic medical record system. Please list your Primary pharmacy; we will not send medications to multiple pharmacies.

Patient Name: ____________________________________DOB: _________

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

Pharmacy Fax Number: ____

Any drug allergies: ____________________________________ ☐ NKDA

Patient Signature: _______________________________ Date: __________