PHARMACY INFORMATION SHEET

PATIENT NAME: _____DATE: _____
DATE OF BIRTH: _____

DO YOU USE A MAIL ORDER PHARMACY FOR YOUR PRIMARY PRESCRIPTION MEDICATIONS?
YES_____NO____

DO YOU GET A 90 DAY SUPPLY? YES____NO____

NAME AND ADDRESS OR MAIL ORDER SERVICE:

PHONE NUMBER OF MAIL ORDER SERVICE:_____

FAX NUMBER OF MAIL ORDER SERVICE:_____

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DO YOU USE A LOCAL PHARMACY FOR ANY OF YOUR RESCRIPTION NEEDS?
YES____NO____

DO YOU GET A 90 DAY SUPPLY? YES____NO____

NAME AND ADDRESS OF PHARMACY:

PHARMACY PHONE NUMBER:_____

PHARMACY FAX NUMBER:_____