



**This will be used for calling in your prescriptions or sending them electronically.
Please inform us if you would like to switch pharmacies.**

MUST BE FULLY COMPLETED

Pharmacy Name : _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

PLEASE LIST YOUR MEDICATIONS, FREQUENCY, DOSAGE:

Use back side if needed!

Patient Signature

Date