



Per new guidelines our office uses electronic prescription services. Please provide the name and address of your preferred pharmacy below.

Patient name: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_

Street address:

\_\_\_\_\_  
\_\_\_\_\_

City:

\_\_\_\_\_

State:

\_\_\_\_\_

Zip code:

\_\_\_\_\_

Phone number:

\_\_\_\_\_

Please list any allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you!