Dear Patient:

For your convenience and safety, we are using a computerized prescription program that will help ensure accuracy and convenience when prescribing your medications. This program will allow for electronic transmission of most of your prescriptions directly to your pharmacy of choice. It will also allow for the electronic submission to many mail order pharmacies as well.

To implement this program effectively, we need to collect some information from you on the pharmacies you use regularly. Please list the pharmacies in the spaces below as well as which mail order pharmacy you use, if any. When you call for refills or when you are in the office please specify which pharmacy you would like to use for refills and new prescriptions.

We understand that you many not have all of this information with you today if you are in the office. Please take this form and bring it back completed at your earliest convenience.

Patient Name: ______________________________ DOB ____________
Drug Allergies: ____

Pharmacy Name: ____
Address: ____
Phone: ____________________________ Fax: ____________________

Pharmacy Name: ____
Address: ____
Phone: ____________________________ Fax: ____________________

Mail Order:

_____ Medco

_____ CareMark

_____ Express Scripts

_____ Pharmacare