Pharmacy Information

Our office participates in E-prescribing for non-controlled substances. Please complete the information below so that we can ensure that any medication prescribed is sent to the correct pharmacy.

Pharmacy name: ______________________________

Pharmacy telephone number: ______________________________

Pharmacy address: ______________________________

Patient name: ______________________ Patient date of birth: ______________

Patient name: ______________________ Patient date of birth: ______________

Patient name: ______________________ Patient date of birth: ______________

Patient name: ______________________ Patient date of birth: ______________

Patient name: ______________________ Patient date of birth: ______________

Parent / Guardian name: ______________________________

Address: ______________________________

Daytime telephone: ______________ / ______________________

Evening telephone: ______________ / ______________________

Parent / Guardian signature: ______________________ Date: ______________