PATIENT PHARMACY INFORMATION:

Please provide us with your preferred pharmacy information, including mail away pharmacy information. Your prescriptions will be sent electronically to your preferred pharmacy.

Patient Name: _____

Pharmacy Name: _____

Complete Address: _____

Phone #: _____

Mail Away Pharmacy: _____

Complete Address: _____

Phone #: _____

Prescription refills can be requested through your pharmacy. We do not call in prescriptions by telephone. Please check if your prescription has refills before calling the office.

THANK YOU!