Pharmacy Patient Information Sheet

Patient Name: _____ Date Of Birth:_____

Dear Patient,

We are very excited to be implementing a new e-prescribe service in our practice. Because we are dedicated to provide exceptional patient care for you, we now offer a new service that allows your prescriptions to be sent electronically to the pharmacy of your choice. Please fill in the form to the best of your knowledge so that we can serve you better. Thank you!

Please list your PRIMARY PHARMACY information:

Name:_____

Address:_____

Phone: _____

Medication Allergies:

_____

_____

_____

We do have our own physician-dispensing pharmacy in our Oxnard office for your prescription needs that any of **our** doctors' prescribe. We do take many Prescription Insurance plans. For your convenience, we offer mail service in addition to having refills available for pick up at any of our offices. Would you be interested in using our pharmacy services to fill your prescriptions **our doctors prescribe** if we can take your insurance and the co-pay would be the same anywhere else?

_____ Yes _____ No

Please list the medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Prescription Insurance Information:

Do you have a separate insurance Card you use for your prescriptions?

_____ Yes _____No

* If you answered yes, please Give your prescription insurance card to us with this form so we can photocopy it.

Thank you for allowing us to Serve You Better!