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Good Medicine Takes Time

PHARMACY & REFERRING PHYSICIAN INFORMATION

To assist in your care, please complete the form below and provide our office with a list of all your doctors and pharmacy information. Thank you!

Date: ______________________

Patient Name: ____

Pharmacy Information:

Name: ____

Address:____

Phone #:_________________________________ Fax #: __________________________________

Primary Care Physician: ____

Address:____

Phone #:_________________________________ Fax #: ___________________________________

Physician (Specialty):____

Address:____

Phone #:_________________________________ Fax #: __________________________________

Physician (Specialty):____

Address:____

Phone #:_________________________________ Fax #: __________________________________