

# PHARMACY UPDATE

In order to better serve your prescription needs, please advise us as to your current pharmacy preferences. This includes a local and a mail order pharmacy.

Patient Name (please print):

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Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

LOCAL PHARMACY AND  
LOCATION: \_\_\_\_\_

MAIL ORDER PHARMACY AND  
LOCATION: \_\_\_\_\_

Please give this completed form to the nurse when you are seen.