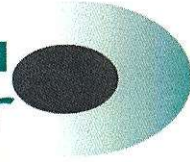


# Bergman Porretta Eye Center



Patient Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

## Main Pharmacy:

\_\_\_\_\_  
Name of Pharmacy (example- Rite Aid, Walgreens, CVS, etc.)

\_\_\_\_\_  
Address & City

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

## Additional Pharmacy:

\_\_\_\_\_  
Name of Pharmacy (example- Rite Aid, Walgreens, CVS, etc.)

\_\_\_\_\_  
Address & City

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

## Mail Order:

\_\_\_\_\_ Medco      \_\_\_\_\_ Express Scripts      \_\_\_\_\_ Caremark      \_\_\_\_\_ Pharmacare

\_\_\_\_\_ Other

Please list any known drug allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_