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:

_____

_____

_____