Primary Local Physician and Pharmacy Information

ALL SECTIONS WITH (*) ARE REQIUIRED FOR APPOINTMENT

Please list the name and location of your primary care physician:

Please list the name and location of your primary/regular OB/GYN (*):

Please list the name and location of your pharmacy:

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure. (required)

Please type your name to sign below: (*)

Date (MM/DD/YYYY): (*)

☐ I am the parent/guardian of this patient