Medical Contacts Worksheet

Please provide us with the information requested below to ensure that we have the correct information to respond to your medication requests and communicate with your physicians.

Patient Name:____

Patient Date of Birth:____

Pharmacy Information: Where would you like prescriptions sent? *CMA to enter into EPIC*

Name:______________________________________ Phone:_____________ Fax:_____________

Address:____ e-mail:_________________________

Primary Care Physician Information: *Front Desk to enter into EPIC*

1. Name:____________________________________ Phone:____________ Fax:_____________

Address:____ e-mail:_________________________

Referring Physician Information: Who sent you to see us? *Front Desk to enter into EPIC*

3. Name:____________________________________ Phone:____________ Fax:_____________

Address:____ e-mail:_________________________

Other Physicians: Do you have a gastroenterologist? *Front Desk to enter into EPIC*

4. Name:____________________________________ Phone:____________ Fax:_____________

Address:____ e-mail:_________________________

Specialty:____

5. Name:____________________________________ Phone:____________ Fax:_____________

Address:____ e-mail:_________________________

Specialty:____