Name: ___________________________________

Date of Birth: ______________________________

Medication: _______________________________

Started taking Medication on this date: _______________________

Did you have issues obtaining or starting this medication?

YES ☐ **NO** ☐

If Yes, select reason:

Insurance/Financial: ☐ **Drug not available at Pharmacy:** ☐

Transportation: ☐

Other:____

Please call the office if you are unable to get this prescription

filled ________in days.

Office Number: ____

For Office Use Only:

Rx Date: ____________________

R/C: ☐