

## Medical Record Update Form

To help us complete and update your medical record, please complete the form below and return it to the reception desk. If you have any questions, please feel free to contact your physician's office.

**Patient Name** (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please list your current medications and dosages:** (Continue on back, if needed)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Usage (example: once nightly): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Usage (example: once nightly): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Usage (example: once nightly): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Usage (example: once nightly): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Usage (example: once nightly): \_\_\_\_\_

**Please list your allergies:** \_\_\_\_\_

**Please list any CURRENT medical conditions you are being treated for:** \_\_\_\_\_

**Pharmacy name:** \_\_\_\_\_

Pharmacy address: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Need prior authorization**  Yes  No

If yes, Insurance company and phone number: \_\_\_\_\_ Insurance ID: \_\_\_\_\_

### Our Team:

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