Dear Patient:
For your convenience and safety, Womens Health Professionals is starting a computerized prescription program that will improve both the accuracy and convenience 01 prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information of additional pharmacies to be used.

PATIENT NAME: _____ Date of Birth: _____

**MAIN PHARMACY:**

Name (i.e. CVS, Rite-Aid, etc): _____
Street Name & City: _____
Phone: Fax: _____

**ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:**

Name (i.e. CVS, Rite-Aid,etc): _____
Street Name & City: _____
Phone: Fax: _____

Name (i.e.CVS, Rite-Aid, etc): _____
Street Name & City: _____
Phone: Fax: _____

**PLEASE LIST ALL YOUR DRUG ALLERGIES:**

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