Robert M. Allar M.D.

Pharmacy Form

Patient Name: _____ Date: _____

Patient Phone Number : _____

We appreciate your patience while we update our records with your Pharmacy information. We have converted to an electronic system and we are required to prescribe medications electronically.

Please provide as much information as possible about your Pharmacy of choice.

Pharmacy:

Pharmacy Name: _____

Pharmacy Address: _____

_____

_____

Pharmacy Phone: _____

Fax Number: _____