



Hillside Family Medicine, LLC

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Medication Dispensary – Patient Information Form

In order to better serve you, we have established a Medication Dispensary within our office. This will allow you to obtain your prescription(s) before you leave our office. We will also be able to provide you with detailed medication consultation and allergy and drug interaction analysis.

Please complete the following:

Name: _____ Date of Birth: _____

Medication Allergies: _____

Current Medications – Please include strength if know.

Indicate date you finish a short-term prescription and circle those used on a long-term basis

Medical Insurance Plan: _____

Does your medical insurance cover prescription medications? Yes No

If Yes please provide your prescription card for us to copy:

Prescription Program Name: _____

Group #: _____ ID#: _____

Co-payments: Generic _____ Brand Name _____

Provider Phone (see back of card): _____

Would you like to have your prescriptions filled at this office: Yes No

Would you like to have your refills processed from this office (either mail or pickup): Yes No

Signature

Date

If you would like us to keep payment information on file for future prescriptions please fill out the following:

Master Card Visa Discover American Express

Credit Card#: _____ Exp Date: _____