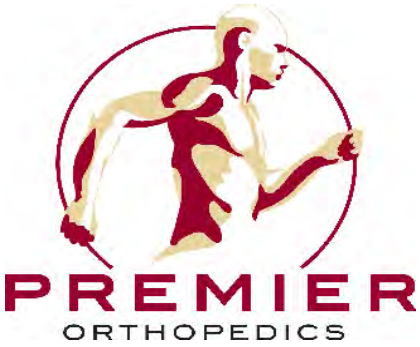

Premier #_____

REQUIRED AT THE TIME OF YOUR APPOINTMENT

Today's Date:_____ **Date of Birth_____**

Name: _____

Your Pharmacy Name_____

CURRENT MEDICATION LIST

List all prescription and over the counter medications you are currently taking (or provide a list):

MEDICATION NAME	MILIGRAMS PRESCRIBED	DOSAGE