Patient Information Form

# **Instructions**

To E-Prescribe: To Fax:

**(801) 590-7003**

Meds in Motion Pharmacy

3798 South 700 East Suite #7

SLC, UT 84106

Phone: (801) 506-6999

NCPDP/NABP: 4162479

NPI: 1164778510

Questions? Call:

**(801) 506-6999**

# **Patient Information**

Patient Name (First & Last):

Phone #:

Address:

City:

DOB:

SS#:

State:

Zip:

# **Physician Contact Information**

Type Doctor Name Here

Type NPI Here

Name: NPI:

Type Address Here

Type Phone # Here

Address: Phone #:s

# **Treatment**

Rx: Lotemax Gel 5ml Qty #: 1

Refills: 6 PRN

Directions: Instill one drop into affected eye(s) 1 time per day for \_\_\_\_ days

Signature: Date:

**Insurance:**

If possible, kindly attach a copy of the patient’s health insurance and Rx coverage card AND a printout of patient demographic information