Pharmacy Information

Date: ____________________

Patient name: ____ Date of birth: ____________

Family doctor: ____

Email address: ____

☐ I choose not to provide my email address at this time. Date and initial: ________________

Riverview Medical Group (RMG) utilizes e-scribing for your prescription needs. If you are in need of a prescription, it will be electronically submitted to the pharmacy of your choice. The pharmacy you list will be the pharmacy that ALL prescriptions from an RMG facility will be sent to. If at any time you would like to choose a different pharmacy, you will need to inform the office that is calling in your prescription.

Local Pharmacy

Name: ____

Address: ____

Phone: ____

Mail-Order Pharmacy

Name: ____

Address: ____

Phone: ____