Prescription Drug List

Your Name: ____ **Phone:** ___________________________

Please print the entire prescription drug name as printed on the bottle.
If the drug is generic, please print the entire generic name.

	Name (as printed on bottle)	Dosage Amount and Type	Pill Amount per day	Pill Amount per month
Ex	*Atorvastatin Calcium*	*20 Mg - Tablet*	*1*	*30*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Your Preferred Pharmacy: ____

Would you be open to changing pharmacies if it can save you money? **YES** **NO**