Prescription Drug List

Name: _____ **Agent:** Jack

Phone: _____ Gina

Email address: _____ Angela

Pharmacy used: _____

Are you willing to change to a lesser expensive pharmacy? Yes / No

Current coverage: _____

Appointment date & time: _____

Please Print Clearly

	Name of prescriptions	**Dose** (mg, mcg)	**Type** (tablet, capsule, liquid, cream)	**Times used per day**	**How often is the prescription filled** (30 days, 90 days, 1 or 2 times per year)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Notes / Requests: _____

_____

_____

_____

Please send to:

diana@strausandassociates.com **Questions? Call: (541)857-8446**

Fax (541)779-5153

Mail: Straus & Associates, Inc., 100 E. Main Street, Suite N, Medford, OR 97501