HOME MEDICATION LIST

Advanced Gastroenterology & Hepatology

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PATIENT NAME: _____

DOB: _____ /_____ /_____

Insurance: Medicare/ BCBS Carefirst/ Aetna/ United Healthcare/ Medicaid/ Other

GENDER: _____

PRIMARY CARE PROVIDER (PCP): _____

PCP PHONE: ( ) _____ - _____

PHARMACY & LOCATION FROM WHICH YOU WOULD LIKE TO PICK UP MEDICATIONS:

_____

Do you have any known allergies? If yes, please complete the list below.

ALLERGY	REACTION
Example) Penicillin OR "No Allergies"	*Example) Rash*

Please complete your medication list below to the best of your ability. You may continue on the back if more space is required.

NAME OF MEDICATION	DOSAGE	FREQUENCY	FILLING DOCTOR/PA
Example) Lisinopril	*40 mg*	*daily*	*Dr. John Smith*