General Prescription Form

Phone (310) 360.9969 Fax (310) 360.9959
7360 Santa Monica Blvd., #101, West Hollywood, CA 90046
cienegapharmacy.com

DATE:______________ NEEDS BY DATE:______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________________________

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis (include ICD-9 code if available)______________________________

DrugAllergies:______________________________

Prior Failed Meds	Length of Treatment	Reason for Discontinuing

PRESCRIPTION INFORMATION

Medication	Strength	Dose/Frequency	Quantity	Refills

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

______________________________ Prescriber's Signature (no stamps)

______________ Date

If Brand required check ❑ DAW

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