MEDICATION NEW PATIENT FORM - PACIFIC SHORES MEDICAL GROUP

Allergies: _____

Pharmacy's name/phone #:_____

Please write in the spaces provided below any medications you are taking including the medication name, strength, directions, date it was prescribed, and the date you started. Please make sure to include any over-the-counter medications, vitamins, and herbal or other supplements. Please write your initials and date at the bottom.

NAME	STRENGTH	DIRECTIONS	DATE PRESCRIBED	START DATE

PATIENT/CAREGIVER INITIALS:_____ **DATE:**_____

Account Number: