My Kid's Doc

SOUTHFIELD

## ELECTRONIC PERSCRIPTIONS FORM

As a convenience to our patients, we are offering electronic prescriptions and prescription renewals. If you are interested, please complete the following questionnaire.

Please be certain that the information you provide is correct. Please ask if you have any questions about medication allergies.

Date completed: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Phone Number: _____

Patient's Zip Code: _____

Medication Allergies and Reactions: _____

Pharmacy Name: _____

Pharmacy City and Cross Streets: _____

If you have other children, you may include them below:

| Name | Date of Birth | Medication Allergies/Reactions |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |