Bethany Women's Healthcare
Patient's Current Medication Information

Name:_____ Date of Birth:_____ Age: ____
(Last) (First) (Initial)

Address:_____ City,State, Zip: _____

E-Mail:_____Primary Phone:_____ Secondary Phone: _____

The following is a list of the prescribed medications, vitamin supplements and herbal remedies I am currently taking.

NAME	DOSAGE	FREQUENCY

IF MORE SPACE IS NEEDED, PLEASE USE THE BACK OF THIS SHEET.

Name of the **pharmacy** you currently use? _____

_____ _____
Pharmacy Location/Address Pharmacy Phone Number

I hereby give my consent for my provider to view and maintain a copy of my **SureScripts** prescription history as part of my clinical medical record. I understand that this information will not be transferred to outside entities without my written consent.

_____
Signature of Patient

_____
Date

1-2017