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PRESCRIPTION REQUEST FORM

Please submit this form ***10 days before*** you need a prescription. Your medication request will be renewed only if you have seen Dr. Hertz in the past 3 months. If you have not seen Dr. Hertz in the past three months, please call the office to make an appointment.

The information requested on this form may be provided by mail, e-mail, fax or telephone. Your prescription will be sent electronically to your pharmacy or mail order service.

***INCOMPLETE REQUESTS WILL NOT BE PROCESSED***

PLEASE PRINT

PATIENT NAME_________________________________________DATE OF BIRTH_______________

MEDICATION NAME_________________________________________________________________

DOSAGE ___________________________________________________________________________

DIRECTIONS (HOW MANY TIMES PER DAY)______________________________________________

30 DAY SUPPLY_____________________________ 90 DAY SUPPLY___________________________

PHARMACY OR MAIL ORDER SERVICE NAME_________________________________________

PHARMACY ADDRESS_______________________________________________________________

PHARMACY ZIPCODE_______________________________________________________________