TRACY'S MEDICINE CENTER
3171 TUCKER NORCROSS ROAD
TUCKER, GA 30084
Phone (770)939-1642
Fax (770)723-9515

Patient Information:

Patient's Name: _____

Address: _____

Phone Number: _____ Date of birth: ___/___/____

List of Drug Allergies (i.e., Penicillin, Aspirin, etc.):_____

_____

List of Other Known Allergies (i.e., Iodine, Seafood, etc.):_____

_____

Primary Physician's Information:

Physician's Name:

_____

Physician's Address:

_____

Office Phone Number: _____

Pharmacy Insurance Information (PLEASE SEND COPY OF CARD(S) FRONT & BACK)

Name of Insurance: _____

Card ID#: _____ Group#: _____

Insured's Name: _____ Ins. Phone #: _____

Medicare #: _____ Social Security #: _____

Do you have mail order pharmacy coverage? Yes___ No___

If yes, do you plan to use the mail order pharmacy and have Moye's repackage? Yes____ No____

(For Office Use Only)

____Medication Management ____Self-medicates

*Medications need to start on ___/___/_____ at _____ am____ pm____

Diagnosis: _____

List of Current Medications: Patient's Name: _____

****Please include Over-The-Counter Medications and Prescriptions****

Name of Medication	Strength	Amount Per Dose	Frequency	Time of Day Med is Taken	Name of Physician

Physicians Name: _____ Phone#:_____

Physicians Name: _____ Phone#:_____

Physicians Name: _____ Phone#:_____

If necessary we may need to call & transfer prescriptions from current pharmacy in order to fill the prescriptions.

Please provide the following information:

Name of Current Pharmacy: _____

Pharmacy's Address: _____

Pharmacy's Phone Number: _____

Additional Comments: _____

_____