# MICHIGAN RHEUMATOLOGY AND WELLNESS CENTER

## PATIENT PHARMACY FORM

**Patient Information:**

- **Full Name: _____Date of Birth: _____**

**Primary (Local) Pharmacy:**

- **Pharmacy Name: _____**
- **Pharmacy Address: _____**
- **City, State, ZIP Code: _____**
- **Pharmacy Phone Number: _____**
- **Pharmacy Fax Number (if known): _____**

**Mail Pharmacy:**

- **Pharmacy Name: _____**
- **Pharmacy Address: _____**
- **City, State, ZIP Code: _____**
- **Pharmacy Phone Number: _____**
- **Pharmacy Fax Number (if known): _____**

**Specialty Pharmacy (if applicable):**

- **Pharmacy Name: _____**
- **Pharmacy Address: _____**
- **City, State, ZIP Code: _____**
- **Pharmacy Phone Number: _____**
- **Pharmacy Fax Number (if known): _____**
- **Medication(s) Managed by this Pharmacy: _____**

**For Office Use Only: Date entered in system: / / . STAFF INITIALS: _____**