PROVIDER AND MEDICATION WORKSHEET

Use additional pages if necessary

Name: _____ Phone: _____

Address: _____ Date of Birth:_____

City _____ State _____ Zip _____ Email: _____

Primary Care Provider Name: _____ Tel_____

Address _____

Preferred area hospital for elective / non-emergency care: _____

SPECIALISTS:

1) Name _____ # Visits Each Year _____

Address _____

2) Name _____ # Visits Each Year _____

Address _____

3) Name _____ # Visits Each Year _____

Address _____

4) Name _____ # Visits Each Year _____

Address _____

5) Name _____ # Visits Each Year _____

Address _____

MEDICATIONS FILLED AT PHARMACY:

Exact Spelling from label	Format	Dosage	Quantity
Ex: Atorvastatin	*tablet*	*125mg*	*2x daily*
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____
4_____	_____	_____	_____
5_____	_____	_____	_____
6_____	_____	_____	_____
7_____	_____	_____	_____

Check if applicable: [ ] I receive Social Security ***Extra Help*** for Part D premium, deductible and copays

[ ] My ***NY State EPIC*** ID is: _____

Please scan and send by email to Dan@DGAlcorn.com (518) 346-2115