STERLING PSYCHIATRY

Pharmacy Update

Patient Name:_____ DOB: _____ / _____ / _____

In order to serve you better, please print and complete all applicable information

Pharmacy Information:

Name: _____ Phone: _____

Address: _____

Mail Order Pharmacy Information:

Name: _____ Phone: _____

Address: _____

Prescription Benefit Plan:

Name: _____ Phone: _____

Address: _____

Member#: _____ Group#: _____

Please provide a copy of your prescription benefit card

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