Taylor Retina Center

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Patient Name:_____ Date: _____

Email (if applicable): _____ Date of Birth:_____

I authorize Taylor Retina Center to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

_____

Patient Signature

Pharmacy Information

(All pharmacy information is not required please put at least the town and street name)

Name of Pharmacy_____ **Phone Number:** _____

Pharmacy Address: _____

City, State, Zip Code: _____

Race: ☐ **American Indian** ☐ **Asian** ☐ **White** ☐ **Black/African American**

☐ **Native American or Pacific Islander** ☐ **Hispanic or Latino**

Other:_____ ☐ **Decline**