HEART AND VASCULAR CARE

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Pharmacy information

Please provide us with your local and any mail order pharmacy information so that we can update our e-prescribing system. In addition, please let us know if you have an email address.

Your Last Name: _____ Your First Name: _____

Your DOB: _____

Your Physician ____ Dr. Khurana

LOCAL PHARMACY

Local Pharmacy Name	
Street Address	
City	
State	
Zip Code	
Phone	( ) _____ - _____

MAIL ORDER PHARMACY Note: Please provide **exact** address and phone number as each RX insurance plan gets sent to different locations of the same pharmacy. If an exact address or phone number is not provided we will be unable to send RXs to your mail order pharmacy.

Mail Order Pharmacy Name	
Street Address	
City	
State	
Zip Code	
Phone	( ) _____ - _____

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