Client Drug List

Name:_____

Date:_____

Phone:_____

County:_____**Zip Code:**_____

Primary Agent:_____

OSBORN & ASSOCIATES

AN INTEGRITY COMPANY

***Do not list over-the-counter medications**
***Only list medications you fill at your pharmacy**

DRUG LIST

Name of Prescription Medication (As it reads on your bottle)	Dose (mg)	How many times a day?	Do you receive a 30 or 90 day fill?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(Please List additional medications on back)

Do you have VA? ___Y___N **Preferred Pharmacy**_____

Do you have Medicaid? ___Y___N **Current Plan** _____

Do you receive extra help? ___Y___N **Preferred Hospital**

Do you prefer mail order? ___Y___N ____Mercy ____Cox Other _____

Primary Physician_____

Comments _____

For office use only: MyMedicare ID:_____**Password:**_____

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