Colleen A. Blanchfield, M.D.
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ePrescribe Registration Form

Date: _____

Patient Information:

Patient's Full Legal Name _____ _____
(first name) (full middle name) (last name)

Patient's Social Security #_____ Patient's Date of Birth_____

Patient's Home Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____

Allergies:

_____

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Mail Away Pharmacy Information

☐ The mail away pharmacy already on file with the office is current and correct.

Pharmacy Name:_____ Phone #_____

Pharmacy Address_____

City_____ State_____ Zip Code_____

Local Pharmacy Information

☐ The local pharmacy already on file with the office is current and correct.

Pharmacy Name:_____ Phone #_____

Pharmacy Address_____

City_____ State_____ Zip Code_____

* Pharmacies listed above that do not contain the complete address and phone number of the pharmacy cannot be verified or entered into our system.