

Athens Gastroenterology Center

PATIENT PRESCRIPTION REFILL REQUEST

You must be a patient of Dr. Smith in order to request refills. To make a request, fax this form to (706) 548-0555. Please be aware that it may take us a certain amount of time to call in your prescription. We will do our best to get it in to your pharmacy as soon as possible. Please call us at the office at (706) 548-0058 if you have any questions.

Last Name: _____

First Name: _____ **Middle Initial:** _____

Birthdate: _____ **Social Security Number:** _____

What do you need refilled? _____

For how long? _____

What are your drug allergies? _____

When was your last visit to our practice? _____

Where can we reach you by telephone? _____

What is your pharmacy name and location? _____

Is there anything else we need to know, like other medicines that your are taking?
