New York Cardiology Associates P.C.

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Date:_____

Patient Name:_____ **Date of Birth:**_____

Our office has started Electronic Prescribing. We request that you list the pharmacy of your choice below. If you use a chain pharmacy, such as Duane Reade or CVS, please include the store number as well as the address and/or phone number. If you use a mail order pharmacy, please indicate which one below.

Pharmacy Name:_____ **Store Number:**_____

Address:_____

Phone Number:_____

Mail Order Pharmacy (Please check only one)

[ ] Medco [ ] Express Scripts [ ] CVS/ Caremark Mail Order
[ ] RightSource Rx [ ] Prescription Solutions [ ] CVS/Caremark Specialty
[ ] Cigna Home Delivery [ ] Costco Mail Order [ ] Aetna Rx Home Delivery
[ ] OTHER: _____

As a component of Electronic Health Record, the government has determined that the following demographics should be included in your patient profile.

Language (Please check only one)

[ ] English [ ] German [ ] French [ ] Vietnamese
[ ] Italian [ ] Mandarin [ ] Spanish [ ] Arabic

Race (Please check only one)

[ ] Asian [ ] Caucasian [ ] Black or African American
[ ] American Indian [ ] Alaska Native [ ] Chinese
[ ] Filipino [ ] Japanese [ ] Native Hawaiian
[ ] Multiracial [ ] Pacific Islander
[ ] Undetermined [ ] Other

Ethnicity (Please check only one)

[ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Other / Undetermined

THE FOLLOWING SECTION IS OPTIONAL:

As a component of Electronic Prescribing, we need your consent to access your medication history from your pharmacies. Please sign your name below if you give your consent.

I give my consent for New York Cardiology Associates to access my medication history via Electronic Prescribing.

Signature:_____