Name

Date

Preferred Pharmacy

Primary Care Doctor

Drug	Generic? Y/N	Dosage	How many per (day, week, month)	How often refilled	Prescribed by (doctor name)	**Tier**	**Tier**

Done by K&Co Agent (columns: Tier, Tier)

Please return *before* your appointment (if possible). Email to brelynn@kirbyandco.net or fax 912-265-6446