E-Prescribing Consent Form

Patient's Name_____ Date of Birth:_____

ROCKY POINT FAMLY DENTISTRY is in the process of implementing e-Prescribe (electronic prescribing) in our ongoing efforts to maximize patient safety.

Total Quality in patient care if just one of our ongoing commitments..

Patient Benefits:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster & easier way to get your prescriptions filled

Please list any DRUG allergies:

_____ _____

_____ _____

_____ _____

Please provide our office with your pharmacy name(s), address & phone number so that we may enter this data into your dental record.

Pharmacy Name (1st Choice)	Pharmacy Name (2nd Choice)
_____	_____
Street Name, Town or Zip Code	Street Name, Town or Zip Code
_____	_____
Phone #	Phone#

Patient Consent:

I agree that **ROCKY POINT FAMILY DENTISTRY** may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. This consent form will be updated on an annual basis.

_____ _____/_____/_____

Patient Signature Date