Southfield CB/GYN Associates

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PRIMARY CARE PHYSICIAN INFORMATION/PHARMACY INFORMATION Date____ **Patient** Name **Patient** Insurance_____ **Primary Care Physician** Name_____ **Primary Care Physician** Phone_____ **Primary Care Physician** Address____ City/State/Zip_____ Have you seen your primary care physician?_____ What hospital network is your primary care physician with?_____ PRIMARY PHARMACY INFORMATION Name of Primary Pharmacy Primary Pharmacy Phone Number_____

Primary Pharmacy Location