

Women First OB / GYN P.C.

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If you have a **preferred pharmacy** where you frequently fill your prescriptions, feel free to leave this pharmacy information **below**. Please allow **24 to 48 hours** for the office to fill **routine** prescription requests. Please note that we may charge for **urgent** prescription requests of **routine** medications. However, we will make every effort to accommodate **true emergencies** in a timely fashion.

Please note that refills on birth control medications require a documented female gynecologic **exam** and/or **Pap** smear within the last year.

Pharmacy Name (✓ Preference)

Pharmacy Phone Number

Pharmacy Name (Alternate Choice)

Pharmacy Phone Number

Remember it is in your best interest to keep this information updated in your records.

Patient Name (Please Print)

Patient Signature

Date

Date of Birth ____ - ____ - ____

Please List ALL Known Drug Allergies:

