

PATIENT INFORMATION				
Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female		Allergies
Date of Birth		SSN#		
Address		City	State	Zip
Phone # (Home)	(Work)	Email address		
INSURANCE INFORMATION				
Primary Insurance			Policyholder	
Group #	Policy #	Phone #		
DIAGNOSIS INFORMATION (Please specify primary and secondary diagnoses)				
<input type="checkbox"/> ICD-9 715.16 Osteoarthritis		<input type="checkbox"/> Other ICD-9 _____		
<input type="checkbox"/> Patient had prior physical therapy				
PREVIOUS MEDICATIONS (Please specify dosage & time on therapy)				
<u>Medication Strength & Dose</u>	<u>Dates of Therapy</u>	<u>Reason for Discontinuing</u>		
PRESCRIPTION INFORMATION				
<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Quantity</u>	<u>Refills</u>
<input type="checkbox"/> Supartz® (Sodium Hyaluronate) 2.5 mL				
<input type="checkbox"/> Other:				
DELIVERY INSTRUCTIONS				
<input type="checkbox"/> Physicians Office Date Required _____				
PHYSICIAN CONTACT INFORMATION & AUTHORIZATION				
Physician Name		Office Contact		
Phone		Fax		
Address				
License #		DEA #		
Physician's Signature: _____ Date: _____ (required to process prescription):				
		THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES " d a w " IN THE BOX BELOW		
				