Advanced Cardiovascular ASSOCIATES, PLC

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MEDICATION INFORMATION:

PATIENT NAME: _____ DOB: _____

PHARMACY NAME: _____ PH# : _____

PHARMACY ADDRESS: _____

Please list all current medications that you are taking, Include the name of the medication, the dosage and how many times a day you take it. Thank you for your assistance.

MEDICATION NAME:	DOSAGE (MG)	HOW OFTEN TAKE:

MEDICATION ALLERGIES: _____

REACTION: _____

PH: 586-566-7870 FAX: 586-566-7850
49050 SCHOENHERR RD STE 100
SHELBY TOWNSHIP, MI 48315

PH: 586-731-7000 FAX: 586-731-8610
44850 MOUND RD
STERLING HEIGHTS, MI 48314

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