Palm Beach Neurological Center

MICHAEL M. TUCHMAN, M.D, FAAN **RHONDA SKILES, ARNP, NP-C**
3365 Burns Road, Suite 203
Palm Beach Gardens, FL 33410
561-694-1010

Patient Name: _____ Chart #: _____

Here at Palm Beach Neurological Center it is our pleasure to conveniently send your prescriptions electronically to your preferred pharmacy. In order to do so we require the following information regarding your pharmacy:

PHARMACY INFORMATION

* Indicates required field

***PHARMACY NAME:** _____

***PHARMACY PHONE #:** _____

PHARMACY FAX #: _____

PHARMACY ADRESS: _____

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