

# 2023/2024 Prescriptions for Individuals

16414 San Pedro Ave, Suite 665, San Antonio, TX 78232 P:  
 210-545-0667 F: 210-545-3766  
[INFO@ZINNINSURANCE.COM](mailto:INFO@ZINNINSURANCE.COM)



Your Name:		Date of birth:	
Your Phone Number:		Zip Code:	
Name of the Pharmacy(IES) you go to:			

**PLEASE FILL OUT FORM AS CLEARLY AS POSSIBLE!**

Please list ALL medications that you take THROUGHOUT THE YEAR and either upload, fax, email the form back to us.

Name of Medication <i>**If you are taking a generic medication, please only include the generic name***</i>	Generic? Y / N	Dosage	Number of times a day you take the drug	How often filled 30, 60, 90 Days	Retail ( R ) or Mail Order ( MO ) Canada (C)	Condition(s) for which meds are prescribed for?
					Please select one	

Please DO NOT include Over the counter Medications (OTC) and/or Vitamins.

\*If you have more medications, please make a second copy of this form!\*

\*\*If you take an RX that is "AS NEEDED" put on form. Frequency should be 12 months.\*\*

*Example*

	<i>metformin hcl tab</i>	<i>Y</i>	<i>500mg</i>	<i>1 x day</i>	<i>30, 60, 90 day</i>		<i>diabetes</i>
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							

I DO NOT TAKE ANY PRESCRIPTION MEDICATIONS!