2024/2025 Prescriptions

16414 San Pedro Ave., Suite 665, San Antonio, TX 78232 P. 210-545-0667 F. 210-545-3766



insureme@zinninsurance.com

Your Name:	Date of
	Birth:
Your Phone Number:	Your 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 or email the form back to us.

Name of Medication	Generic?	Dosage	Number	Frequency	Retail (R)	Condition(s) for
if you are taking generic	Y/N		of times a	of Refills	Mail Order	which meds are
medication, please only			day you	30, 60 or	(MO)	prescribed for?
include the generic			take the	90 Days	Canada (C)	
name			drug		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 a prescription that is "AS NEEDED" include on this form with frequency noted as 12 months.

EX: metaformin hcl tab	Y	500 mg	1 x day	90 days	Retail	diabetes

		I DO NO	OT TAKE ANY	PRESCRIPTIO	N MEDICATION	S
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2024/2025 Doctors

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Your Name:			Date of Birth:			
Your Phone			Your Zi	p Code:		
Number:						
	PLEASE FILL	OUT FORM AS CLE	ARLY AS	POSSIBLE!		
Please list all do	ctors and specialists	you see and either	upload, f	fax or email the	e form back to us.	
Dr.'s First Name	Dr.'s Last Name	City, State, Zip Co	de	Phone	Specialty	
	<u> </u>	<u>I</u>		1	1	
	I DO NOT SEE ANY D	OCTORS REGULARI	Υ.			
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