Medication Order Form Toll Free Fax: 866-407-8689

Name:_____ Date: _____

Date of Birth:_____ Phone # (___)_____

Mailing Address:_____Apt:_____

City:_____ State:_____Zip Code:_____

Height:_____ Weight:_____ Gender: ____M____F

Requested Medication	Dosage	Quantity	Price
		Shipping	$ 13.00
		Total Enclosed	

Known Drug Allergies:

Current Medications:

1. _____ Condition _____
2. _____ Condition _____
3. _____ Condition _____

_____

Patient Counseling: Are any of these medications new? ☐ Yes ☐ No
Do you require pharmacist consultation? ☐Yes ☐ No

Payment Method ___MasterCard ___Visa ___Money Order ___Certified Check

Name on Card:_____Exp:_____
Credit Card #_____CVV2 Code*_____

Signature:Typed_____ **Date**:_____

*The CVV2 code is the last 3 digits printed on the signature strip on the back of your card. This is not required.