

Patient:

Prescription Order Form

 Name Date

 Address

 City State Zip

 Phone (H) (W)

 Date of Birth Allergies

Contact patient for insurance information (check box if applicable)

Prescription:

Drug	Strength	Dosage Form	Quantity
Directions (Dose, Route of Administration, Frequency)			Refills

Doctor Information:

 Doctor Name (Please Print) Signature

 DEA# Licence Phone Number Fax Number

 Doctor Address (if first time ordering) City State Zip

Shipping Information:(please check all that apply)

___ Ship to Doctor ___ Ship to Patient ___ Bill credit card on file

___ Bill the following credit card ___ Ship C.O.D.

Name on Card: _____ ___ UPS

_____ ___ Send Overnight

Exp. date _____