

Form 5

Affiliate #

PRESCRIPTION REORDER REQUEST FORM

First Name: _____ Last Name: _____
 Address: _____
 City: _____ State: _____
 Zip Code: _____ Phone: _____

Is this an address change? Yes _____ No _____

Has your health status changed since your last refill?
 (i.e. allergies, new diagnosis) Yes _____ No _____

If yes please explain: _____

Have you taken any new medication(s) since your last fill? Yes _____ No _____

If yes please list the medication name(s) and strength(s): _____

PRESCRIPTION REQUEST FORM

Prescription number (Found top left hand corner: Rx#)	Medication Name	Quantity
1)		
2)		
3)		
4)		
5)		
6)		

Shipping Fee Reminder: \$16.00 for Expedited, \$26.00 for Express

MY BILLING INFORMATION

Please input the *EXACT* credit card billing information, or your order *will be delayed*.

Type of card: Visa _____ MasterCard _____ American Express _____

Cardholder's Name: _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Address to send receipt to: _____

A reminder to please consult your doctor or pharmacist before taking any medications not prescribed by your doctor.

Patient Signature: _____

Print Patient Name: _____

Date Signed: _____

Fax or mail your completed form