



Order Form

Date:

Please fax completed forms to Domestic 866.480.3322 • International 561.989.1595

Patient Information				
Name: (print)		Date of Birth:		
Street:	City:	State:	Zip:	
Phone:	Cell:	Work:		
Email:				
Allergies:				
Prescription Information				
#	Physician Order	Size	Refills	Quantity
Doctor Information				
Name: (print)		Signature:		
DEA #:		State License #:		
Street:	City:	State:	Zip:	
Phone:	Fax:	Email:		
Credit Card Information				
Card Type:	Visa	MasterCard	Amex	Discover
Card Holders Name:				
Card Number:		Exp. Date:	CCV#:	
Billing Info: (if different from above)				
Street:	City:	State:	Zip:	
Billing Phone:		Signature:		
Shipping / Billing Instructions				
<i>Please check all that apply</i>				
<input type="checkbox"/>	Ship to Doctor	<input type="checkbox"/>	Charge Doctor	<input type="checkbox"/>
<input type="checkbox"/>	Ship to Patient	<input type="checkbox"/>	Charge Patient	<input type="checkbox"/>
<input type="checkbox"/>	Include invoice	<input type="checkbox"/>	Do not include invoice	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Overnight	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	2nd Day	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Three Day	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Ground	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Same Day	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Intl	<input type="checkbox"/>

Form# 808001