

# The Mail Service Pharmacy Order Form

(Please print in black or blue ink)

Member ID #

Date of Birth

Gender

 -  -  F  M

Last Name

Delivery Address - Line 1

First Name

MI

Delivery Address - Line 2

Phone Number

City

State

Email Address:

Zip

Doctor Name (Last, First)

Doctor Phone Number

## Health History

Please complete if not reported previously or a change has occurred.

### Allergies:

- |  |   |                                     |                                       |                                       |
|--|---|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> No Known                      | <input type="checkbox"/> Cephalosporins     | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Ampicillin   | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Sulfonamides/Sulfa | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Quinolones   |
| <input type="checkbox"/> Other (please specify): _____ |   |                                     |                                       |                                       |

### Health Conditions:

- |  |   |                                       |   |  |
|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Other (please specify): _____ |   |                                       |   |  |

Please list any Over The Counter or Herbal Medications you take regularly:

## Special Instructions

In order to provide you with high quality medications at the best possible price, we substitute FDA-approved generic equivalents for brand name medications whenever possible. Generic medications will not be sent if your doctor indicates a brand name medication should be dispensed. **If you require a brand name medication for this order, please check the box below and list all medication names\*:**

\*Brand name medications may be subject to a higher cost.

## Payment & Shipping Information Do Not Send Cash

Standard shipping of your order is free and most are shipped by the U.S. Postal Service. Please note, the shipment method will not expedite processing time. If you require a faster shipping method for this order, please indicate below.

Use credit card on file  Overnight Shipment Method - Add \$12.50 to order amount

Use enclosed check for payment  
All checks must be signed and made payable to Prescription Solutions

Use credit card for payment: (Visa, MasterCard, Discover, American Express)

Credit Card Number:

Exp. Date (month/year)

 / 

Signature: \_\_\_\_\_

This credit card will be billed for medicine costs, expedited shipping (if applicable), and any outstanding balances. It will also be billed for all future orders, unless you provide a different form of payment. Payment in excess of amounts due will be credited to your Prescription Solutions account. If method of payment is not indicated, Prescription Solutions will apply the charges to the credit card on file.

Please be sure to include this order form and your original prescription(s).

RXS-RXWB08