Prescription Solutions Mail Service Pharmacy Prescription Order Form

Confidential Patient Profile
Please complete and return with your prescription order.

Please print.

Last Name

First Name

MI

Date of Birth

— —

For identification accuracy, please write your date of birth on each prescription.

Gender

F M

All prescriptions submitted will be filled unless otherwise specified. If you have special instructions, i.e. prescriptions you don't want filled or if you require brand-name for specific medications, please specify in the area below.

Number of Prescriptions

Doctor's Phone Number

— —

Doctor's Name

Drug Allergies

Please check all that apply.

Ampicillin Aspirin Cephalosporins Codeine Sulfa

Erythromycin Penicillin Tetracyclines None

Please specify any other drug allergies not listed:

ID Number

Daytime Phone #

— —

E-mail Address

Shipping Address

City

State

ZIP

Check or Money Order (Payable to Prescription Solutions)

Credit Card (select one): Visa MasterCard Discover American Express

Credit Card Number

Expiration (month/year)

/

I certify the information on this form is correct. I assume financial responsibility for these charges. Payment in excess of amounts due will be applied to my account. If method of payment is not indicated, I authorize Prescription Solutions to apply the charges to my credit card on file.

Cardholder Name

Cardholder Signature

Date

➢ **Send via U.S. Mail to: Prescription Solutions, P.O. Box 509075, San Diego, CA 92150-9075**

Be sure to include this order form and your original prescription(s). Please call 1-877-889-6474 with any questions.
Visit our Web site at www.rxsolutions.com