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

Number of Prescriptions

Doctor's Phone Number (___-___-____)

Doctor's Name

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.

_____

_____

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