

New Customer Order Forms

Thank you for your interest in North Country Rx prescription service. You can save from **20-85%** on the cost of your medications by getting your prescriptions filled at Universal Drugstore.

Customer Information

Male
 Female

Patient Name _____ Birthdate (MM/DD/YY) ____/____/____

Shipping Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____

Email Address _____

Secondary Contact

Full Name of Secondary Contact _____

Relationship To You _____ Phone Number _____

Your Physician

Primary Physician's Name _____

Phone Number _____ Ext. _____ Fax Number _____

Referred by: Full Name: _____ Phone #: _____

Medications Order Form (Attach additional sheet if required) **Important: Original Prescriptions must accompany this form**

Brand Only	Generics Permitted	Requested Medications	Strength	QTY	Price
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>				

Promo Code: _____	Please note that we will fill your prescription where applicable in the manufacturer's sealed containers. For example, if your prescription calls for 90 tablets, but the manufacturer supplies bottles of 100, we will fill for 100 tablets.	Add \$10.00 Shipping & Handling to U.S. (Insured Shipping via Express Post)	\$10.00
		(Payment in U.S. Funds) Total Enclosed	

Drug Information

Please choose one of the following 3 options:

I understand my medications and do not need to speak to a pharmacist or receive information sheets.

I do require medication information sheet only.

I would like to speak to a pharmacist about my medications.

*** If you require drug information as indicated above, how would you like to be contacted?**
 (Please note: A pharmacist may contact you with any questions regarding your medication)

Telephone: _____

Fax: _____

Email Address: _____

Current Medications

This is for our records only and will be kept confidential. Listing other medications that you are currently taking will help us create a more complete medical history for you.

Please list any known drug allergies.

Medical History (attach separate sheet if required)

Please list present illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc.

Customer's Name (Please Print)

Phone #

Customer's Signature

Date

Attach Your Prescriptions Here

(Please ensure that we can see the entire prescription)

Please use additional pieces of paper if you cannot fit all of your prescriptions in the designated area