



## New Customer Order Forms

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

**Important: If you do not get a confirmation call from us within 48 hours of sending this fax order please call us at 1.866.456.2456.**

### Customer Information

Male /  Female Birthdate (MM/DD/YY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 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"/>				

<b>Promo Code:</b> _____	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.	Shipping	<b>\$7.00</b>
		(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