



Fax Order Form: 1- 888- 886- 4066

Please write in BLOCK LETTERS.

DETAILS

Title: Mr./Mrs./Ms./Dr.

First Name: Phone:

Middle Name: Fax:

Last Name: Email:

Address:

.....

City:

State:

Zip Code:

Country:

DELIVERY DETAILS (If different from above)

Address: Phone:

..... Fax:

City:

State:

Zip Code:

Country:

CUSTOMER INFORMATION

Do you have any of the following drug allergies?

(Only required if you are ordering prescription medication)

Please tick the appropriate box (es) below:

No drug allergies

Codeine

Penicillin

Tetracycline

Aspirin

Erthromycin

Sulpha

Other drug allergies:

.....

Do you have any of the following medical conditions?

(Only required if you are ordering prescription medication)

- | | |
|--|--|
| <input type="checkbox"/> No Chronic Conditions | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Condition |

Other drug allergies:

Other medical conditions:

| Please Complete All Information Regarding Your Order | | | | | | |
|---|--------------|----------|-----------|-----|-------------------|--------------------|
| <p>Please Write in Block Capitals.</p> <p>Please give full details of each product ordered i.e. – product name, strength, pack size, Qty required, and price as shown on the website. IF YOU ARE SENDING PRESCRIPTIONS FOR MORE THAN ONE PERSON PLEASE FILL OUT AN ORDER FORM FOR EACH INDIVIDUAL PERSON.</p> | | | | | | |
| Item No: | Product Name | Strength | Pack Size | Qty | Price per Product | Total Price |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| | | | | | | \$ |
| Sub Total | | | | | | US\$ |
| (Registered Freight add \$12.50 if Total order < \$150, otherwise Freight is FREE) | | | | | | Add Freight |
| Other charges | | | | | | US\$ |
| Your Total Payable | | | | | | US\$ |

DOCTOR'S DETAILS
(Only required if you are ordering prescription medication)

Doctor's Name:

Prescription Number (if applicable):

Address:

City:

State:

Zip code:

Doctor's Ph:

Fax No:

Note: By faxing this form along with your valid prescription/personal declaration- You are authorizing dispensarymeds.com to act as an agent to forward your prescription onto one of our Member Pharmacies for processing.

If you have questions about your order or wish to order a refill please contact us by phoning our toll free voice message service 1-888-886-4066 or emailing: enquiries@dispensarymeds.com

Dispensary Meds: Visit us at:
www.dispensarymeds.com

Toll Free Fax: 1-888-886-4066
enquiries@dispensarymeds.com