**Family Drugstore**
4060 N Dixie Hwy, Boca Raton, FL 33431

e-Mail: orders@FamilyDrugstore.com
Phone: 866-321-5010 Fax: 866-523-7847

# Prescription Order Form

Please complete a separate form for each family member enrolling in our mail order services. Your order may be delayed if any information is missing or incomplete. Please mail this form to the address above.

**Privacy Notice:** We cannot discuss health information about any patient with anyone other than the patient, the patient's parents or legal guardians (for minors), or individuals with medical power of attorney.

## Patient Information

Name (last) ______ (first) ______ (middle) ______
Address ______
City ______ State ______ ZIP ______
Home Phone ______ Alternate Phone ______ ☐ Male ☐ Female
Email Address ______ Date of Birth ______
Allergies (drug, other) ______
Health Conditions ______
Current Medications ______

## Insurance Information or Prescription Plan Information

Only required if you are new to the Mail Order Pharmacy or if your information has changed since your last order.

☐ I am a new customer. ☐ My insurance information has changed.

Insurance Company/Prescription Plan Name ______
ID# ______ Phone ______
Name of Insured/Policy Holder (last) ______ (first) ______ (middle) ______
Relationship to Insured/Policy Holder ______
Group Number ______ Employer ______
Prefer Brand Name Drugs?* ☐ Yes ☐ No

*Your co-pays may be significantly affected if you select Yes.
If you are Medicare or Medicaid eligible, please call 866-660-3177 or e-mail orders@FamilyDrugstore.com to set up your profile.

## Healthcare Provider Information (please provide information on the prescribing physician)

Physician Name ______ Phone ______

## OR Credit Card Payment Information ☐ Visa ☐ MasterCard ☐ American Express

Card # ______ Expiration Date: ______ 3 Digit Code # (back of card) ______
Name on Credit Card: ______ Credit Card Phone Number: ______
Credit Card Billing Address: ______ Credit Card City / State / Zip: ______

## Prescription Details

| New* | Refill | Transfer** | Prescription Name | Quantity | Strength | Rx Number (For refills enter number on label) |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | | | | |
| ☐ | ☐ | ☐ | | | | |
| ☐ | ☐ | ☐ | | | | |
| ☐ | ☐ | ☐ | | | | |

**Transfer - Please provide the following: Transfer Pharmacy Name ______ Phone ______

*New: Customer must mail or fax the original RX.

☐ I have a written prescription (Please attach)

If you have more prescriptions, please attach

Signature ______

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