National RX

| Phone No: | Internet |
|---|---|
| 888-317-0851 | www.nationalrxga.com |

## Personal Information

_____ ☐ Male ☐ Female
Your Full Name (please print clearly)

_____
Street Address

_____
City | State/Province | Country | Zip/Postal Code

_____
Phone (Home) | Phone (Other)

_____ / /
Email | Birthdate (MM/DD/YY)

_____
Best time to be contacted

**Please fill out this section if you are a first time patient or to update existing information.**

## Secondary Contact

_____
Full Name of Secondary Contact

_____
Relationship To You | Phone Number

## Your Physician

_____
Primary Physician's Name

_____
Clinic Name, Street Address

_____
City | State/Province | Country | Zip/Postal Code

_____
Phone Number | Ext. | Fax Number

_____
Email

## Allergies

Do you have any known drug allergies? ☐ Yes ☐ No
If yes, please entrer the drugs you are allergic to:

_____

## Medication, OTC, Herbal Products You Are Currently Taking

(only list medications you are not ordering)

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Referral Rewards Program *Earn credits for yourself and the person who referred you!*

_____
Full Name of person who referred you | Phone Number

☐ **Please send me a Referral Rewards Program package**

## Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in from your Doctor). **PRICING IN $US DOLLARS.**

**Would you like to receive a call to remind you of future refills?** ☐ Yes ☐ No

**Please check if you are placing this order for a pet.**

☐ Cat ☐ Dog ☐ Other (please specify) _____

Pet Name: _____

| GENERIC OK? | MEDICATION | STRENGTH | QTY | PRICE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | SHIPPING: | FREE |
| | | | TOTAL: | |

## Payment Options *(Please Select One)*

① **CREDIT CARD** ☐ Visa ☐ Mastercard (We do not accept Discover or American Express)

_____
Cardholder's Name

_____
Cardholder's Address

_____
City | State/Province | Country | Zip/Postal Code

_____
Credit Card Number | Expiry (MM/YY) | CVV Code

**OR**

② **Personal Checking Account**
**Make a payment by check and mail it to:**
**National-Rx.com**

## Patient Authorization (Please Check One)

National-RX™ Customer Care operates a marketing and call centre business in Decatur GA, US, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales as between the National-RX™ authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

_____ / /
Patient's Signature | Date (MM/DD/YY)

**PSC:** **MKT:** **AFF:**

National RX

| Phone No: | Internet |
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Please use this form to submit your prescription(s), and send it back to us to complete your order.

Order Number (if available)

## ☐ Option 1: Contact Your Doctor*

Physician's Name

Clinic Name, Street Address

City | State/Province | Country | Zip/Postal Code

Phone Number | Ext. | Fax Number

## ☐ Option 2: Transfer From Another Pharmacy*

Pharmacy Name

Street Address

City | State/Province | Country | Zip/Postal Code

Phone Number | Ext. | Fax Number

Please list the medications you would like us to call your doctor for, or to transfer from another pharmacy.

| Drug Name | Strength | Directions | Rx Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

* Contacting your doctor and transferring from another pharmacy is only available to residents of the United States and Canada

## ☐ Option 3: Mail Your Prescription

Please mail this form and your prescription to:

National-RX
2107 N Decatur Rd
Ste 190 Decatur, GA
30033-5305

**NOTE:** If you have faxed your prescription previously, we are still in need of the original copy to be able to process your order.

**PSC:** **MKT:** **AFF:**