

1. Complete Patient Information

First Name _____ MI _____ Last Name _____ Suffix _____ Date of Birth (MM/DD/YYYY) _____

Permanent Address _____

City _____ State _____ Zip Code _____

Email Address (for shipping notification) _____ Preferred Phone Number (____)____-____

Check one: Home Cell

Gender: Male Female

Drug Allergies: None Codeine Penicillin Aspirin Sulfa Other

2. List Prescriptions

Prescriber Name	Prescriber Phone #

Drug Name/Strength	Directions	Fill Now	Hold for later fill
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>

Please enroll my prescriptions in Automatic Refills (Note. Some state/federally funded insurance companies do not allow automated refills. You will receive a phone call if we are unable to accommodate your request.)

3. Enter Payment Information

Credit Card Type: American Express Discover MasterCard Visa

Credit card Number _____ Expiration (MM/YY) _____

First Name _____ MI _____ Last Name _____ Suffix _____

Permanent Address _____

City _____ State _____ Zip Code _____

If billing address is same as permanent address, please check here:

Please choose one of the following options:

- Place the credit card information above on file for **patient associated with this order.**
- Place the credit card information above on file for the recurrent use for the **patient associated with this order and future orders.**

By signing below, I authorize Wegmans to charge the credit card identified above for this order and all future orders associated with this patient and additional patient(s) listed above, and that at my verbal request; Wegmans may update my billing address and/or credit card expiration date on file.

Cardholder Signature: _____ Date: _____

For Internal Use Only	
Specialist Signature: _____	Date Received: _____