

**1. Patient Information**

Male      /      /  
 Female      Birthdate (MM/DD/YY)  
 Full Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

**2. Secondary Contact**

Full Name of Secondary Contact \_\_\_\_\_  
 Relationship To You \_\_\_\_\_ Phone Number \_\_\_\_\_  
**Your Physician**  
 Primary Physician's Name \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_ Fax Number \_\_\_\_\_

In order to offer you the highest possible level of confidentiality, representatives of CanadaMedicineShop.com will not share the details of this form with any person(s) not listed in the above section.

**3. Patient Counselling Information**

All patients receiving prescriptions from a B.C. pharmacy have the right to receive counselling from a licensed pharmacist.

Would you like a pharmacist to call you to provide patient counselling?     Yes     No

Do you have any known drug allergies?     Yes     No

If yes, please enter the drug(s) you are allergic to: \_\_\_\_\_  
 \_\_\_\_\_

**4. Medication You Are Currently Taking (Not Being Ordered)**

MEDICATION	DOSAGE	FREQUENCY

**5. Medication You Are Ordering**

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. Please remember that medications can only be ordered if accompanied with a copy of the original prescription from your doctor's office. If more space is needed please include an extra page.

OK TO REPLACE WITH GENERIC?

	MEDICATION	STRENGTH	QTY	PRICE
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
SHIPPING (Shipping Fee \$9.99, or FREE on orders over \$100)				
TOTAL				

Check box if you do **NOT** want childproof caps.

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

Cat     Dog     Other (Please specify) \_\_\_\_\_

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

Do you smoke?     Yes     No

Do you wear contact lenses?     Yes     No

**6. Payment Options (Credit Card or Check)**

**Credit Card**

Credit Card Type:     Visa     MasterCard

Cardholder's Name \_\_\_\_\_  
 Cardholder's Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Credit Card Number \_\_\_\_\_ CVV2 \_\_\_\_\_ Credit Card Expiry (MM/YY) \_\_\_\_\_

**TO PAY BY CHECK**

Please make payment to **CanadaMedicineShop.com** and mail to:  
 Canada Medicine Shop 1685 H Street #1415 Blaine, WA 98230

**Referred By:**

Full Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
**Patient's Name (Print Clearly)**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date (Month/Day/Year)**