

PLEASE FAX THIS FORM TO

800-886-9273 (San Antonio) or 830-816-5911 (Boerne)

PHYSICIAN INFORMATION

Physician Name	DEA#
Practice Name	NPI
Contact	Phone
Address	Phone
	Fax
Email	

PATIENT INFORMATION

Patient Name	DOB / /
Address	Phone
	Phone
Allergies	

BILL TO: PATIENT PHYSICIAN

CREDIT CARD: <input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> DISC <input type="checkbox"/> AMEX	/ / /
Billing Street Address:	Billing Zip: Exp / S.C.

SHIP TO: PATIENT PHYSICIAN

PICK UP GROUND \$12.00 2 DAY AIR \$19.00 NEXT DAY AIR \$33.00 COURIER

Notes:

Syringes: IM : QTY: _____ SQ : QTY: _____ **Needles:** IM : QTY: _____

Recon: IM Recon (10ML) : QTY: _____ Bacteriostatic Water (30ML) : QTY: _____

Other: Sharps Container : QTY: _____

Note: Pre-printed prescription forms are not valid in Nevada and Indiana. **May take 1-2 days to process your order*

Compounded Medication	Compounded Medication
Quantity	Quantity
Sig:	Sig:
Refills:	Refills:
<input type="checkbox"/> Manuf. Product Preferred	<input type="checkbox"/> Manuf. Product Preferred

Physician Signature: _____ Date: _____