

New Prescription Order Form



PATIENT NAME: _____

PATIENT DOB: _____ CONTACT PHONE NO. (____) _____ - _____

PRESCRIPTION PLAN: **PTRX** _____

CARDHOLDER ID NO.: _____ EMPLOYER NAME: _____

DRUG ALLERGIES (if so please list): _____

SHIPPING ADDRESS: _____

NUMBER OF PRESCRIPTIONS ENCLOSED: _____

Prescription(s) should be (select one):

- Place all on file until patient notification
- Fill all upon receipt
- See notes below

- BILLING:
- Please send me an invoice if billing information not on file (Prescriptions shipped upon receipt of payment)
 - Check-by-phone (Please call a billing representative at 888-637-5121)
 - Check / Money Order Enclosed
 - Please use card on file
 - Credit / Debit Card (please circle one):

American Express Visa MasterCard Discover

Credit Card Number: _____ CID # (3-4 numbers) _____

Expiration Date (mm/yy) _____ - _____

Can SDRx use the specified card for future orders / unpaid balances?
(circle one) Yes No

I authorize this charge and future prescription charges

Signature: _____

CID # LOCATIONS:

VISA, MasterCard and Discover:

Back of the card: if present, 3 digits in the signature area to the right of the credit card number.

American Express:

Front of the card: 4 digits on the right above the card number

NOTES TO PHARMACY: _____

**Mail Form and Prescription(s) to
P.O. Box 696054
San Antonio, TX 78269**