



Patient Information

Last Name _____
 First Name _____ MI _____
 Date of Birth _____ Male Female
 Primary Prescriber _____
 Prescriber Phone # _____
 Medical Record # (if applicable) _____

Allergies (Check all that apply)

None known Aspirin Codeine
 Erythromycin Penicillin Morphine Sulfa
 Other _____

Medical Conditions (Check all that apply)

None known Active Ulcer Arthritis
 Asthma Congestive Heart Failure Diabetes
 High Blood Pressure Hyperthyroid
 Hypothyroid Kidney Disorder Liver disorder
 Other _____

Shipping Information

Permanent address Address for this order only
 Address _____

 City _____ State _____ Zip _____
 Daytime Phone _____
 E-mail Address _____

Prescription Insurance Information

Insurance plan _____
 Group name/number _____
 Cardholder ID number _____
 Primary cardholder name _____
 Relationship to cardholder: Self Spouse
 Child/Dependant
 Insurance phone # _____
 (refer to back of insurance card).

Insurance customers: Please note, your prescriptions will be filled in accordance with your plan limitations. If you have any questions, please contact your benefits coordinator.

Payment Information

Check enclosed Credit card Money Order
    

Credit card number _____
 Expiration date _____
 Name on card _____
 Signature of cardholder _____

Generic Preference

Generics OK? Yes No

Note: Checking no may result in higher prices or copays. Some plans require prescriptions to be filled using a generic alternative. In all cases, we will conform to your plan's limitations.

Safety Cap Preference

Federal Law requires us to dispense your medication with a child-resistant cap. If you do **NOT** want to receive your medications with child-resistant caps, please sign below.

Signed _____

Prescription Items (new, refill & transfer)

(For transfers) Pharmacy Name & Phone number	Prescriber Name & Phone number	Rx #	Medication Name & Strength	Qty.	Price/Copay
1					
2					
3					
4					

Non-Prescription Items

Item #	Item Description	Qty.	Price Each	Total Price
	<i>Shipping Charge (add \$5.95 for orders containing only non-prescription items):</i>			
	TOTAL AMOUNT OF ORDER:			

Please complete this form and return it to the address below.
 Be sure to enclose your original prescription(s) along with your check, money order or charge information.

Wellpartner, P.O. Box 5909, Portland, OR 97228-5909
 877-935-5797 toll-free or 503-718-5757 (in Portland) www.wellpartner.com

