

<input type="checkbox"/> New to Therapy
<input type="checkbox"/> Current Therapy

Customer Information

Customer Name: _____
 Date of Birth: _____ Gender: Male or Female
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of customer's prescription insurance card(s), if applicable.
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Customer: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/Organization Name: _____
 Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.

Clinical Information and Prescription

Primary Diagnosis: ICD-10 Code: _____
 Description: _____
 Date of Diagnosis or Years with Disease: _____
 Patient's Allergies: _____

 Latex allergy: yes no
 Patient Weight: _____ Patient Height: _____ Date: _____



Date Shipment Needed: _____ **Ship to:** Patient Prescriber Clinic
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X

Physician Signature (no stamps) _____ **Date** _____
 If physician requests brand name only, "DAW"
MUST BE HANDWRITTEN in the following space provided: