

# ABC Online Pharmacy

## Refill Form

Surname _____	Given Name _____	Phone # _____	Alternate phone # _____
Address _____	Date of Birth ____/____/____	E-mail _____	
City _____	State _____	Zip Code _____	Physician's Name _____
			Phone # _____

### Medication You Wish To Order

Name of Drug	Brand/Generic	Strength	Quantity	Reason for Taking
**Lipitor	Brand	40mg	90	High Cholesterol

Medication will be sold in available packet sizes. \*\* Indicates an example entry

### Credit Card Information

Credit Card Number \_\_\_\_\_

Expiry Date \_\_\_\_/\_\_\_\_ Cardholder Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip Code \_\_\_\_\_

Same as last order \_\_\_\_\_ Last 4 Digits \_\_\_\_\_

( ) Visa ( ) MasterCard ( ) Money Order/Check \*\*

\*\* Expect longer processing time(up to one month) if you are paying with Check or Money Order

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_