



MEMBER INFORMATION

(844) 553-7500 | WWW.PRAXISRX.COM

CARDHOLDER ID# (REFER TO ID CARD)

Grid for Cardholder ID#

GROUP # (REFER TO ID CARD IF APPLICABLE)

Grid for Group #

LAST NAME OF CARDHOLDER

Grid for Last Name

FIRST NAME OF CARDHOLDER

Grid for First Name

DELIVERY ADDRESS (STREET AND APARTMENT NUMBER)

Grid for Delivery Address

CITY

Grid for City

STATE

Grid for State

ZIP CODE

Grid for Zip Code

EMAIL ADDRESS

Grid for Email Address

DAYTIME PHONE NUMBER

Grid for Daytime Phone Number

DATE OF BIRTH (MM/DD/YYYY)

Grid for Date of Birth

GENDER

Gender selection boxes (M/F)

Drug Allergies:

- No Known Allergy, Aspirin, Codeine, Erythromycin, Iodine, Other, Penicillin, Sulfa

Health Conditions:

- Arthritis, Asthma, Depression, Diabetes, Epilepsy, Glaucoma, Heart Condition, High Blood Pressure, Other, High Cholesterol, Thyroid, Ulcer

List any OTC, herbal, or other medications you take regularly:

PAYMENT OPTIONS

Payment is due with each order. Do not send cash. If you use a credit card for payment, PraxisRx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Credit Card Type (Our preferred payment method for faster service)

- MasterCard, Visa, American Express, Discover, Use credit card on file, Please place credit card on file for future orders

ACCOUNT NUMBER

Grid for Account Number

EXPIRATION DATE

Grid for Expiration Date

SECURITY CODE

Grid for Security Code

Check or money order enclosed. Cardholder Signature: Date:

Notes to Pharmacy:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to PraxisRx Pharmacy.

Signature: Date:

To refuse generics check here ( ), AND sign and date. PraxisRx Pharmacy substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products. "I understand that I have the right to refuse generic medications. I understand this may result in a high cost to me, that I am responsible for payment, and that the drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept the conditions."

Signature: Date: