

Mailing Address:

3505 8th St. South, Suite 9, Moorhead Minn, 56560-5108

Personal Information

Full Name (please print clearly) Male Female

Street Address

City State Country Zip Code

Phone (Home) Phone (Other)

Email Birthdate (MM/DD/YY)

Best time to be contacted

Would you like to receive a call to remind you of future refills?
 Yes No

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, faxed or emailed).

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
Shipping:				FREE
<input type="checkbox"/> Check box if you do NOT want childproof caps.				TOTAL:

Payment Options

Credit Card Visa MasterCard (We do not accept Discover, American Express, or Diners Club)

Cardholder's Name

Cardholder's Address

City State Country Zip Code

Credit Card Number

Credit Card Expiry (MM/YY) CVV Code

OR **Personal Checking Account (Check or EFT)**
USA/Canada Only

- Use my check information "on file"
- I will send a VOIDED check by:
 - Fax
 - Email
 - Mail
- I will make a payment by check, and mail it to:

USDrugs.com
Suite 9 3505 8th Street South
Moorhead MN, 56560-5108

First Time Patients

Secondary Contact please fill out this section if you are a first time patient, or would like to update your information with us.

Full Name of Secondary Contact

Relationship To You Phone Number

Your Physician

Primary Physician's Name

Clinic Name, Street Address

City State Country Zip Code

Phone Number Ext. Fax Number

Allergies

Do you have any known drug allergies? Yes No
If yes, please enter the drug(s) you are allergic to:

Medical Conditions

please list any medical conditions you may currently have as they may affect any new medications prescribed

Medication, OTC, Herbal Products You Are Currently Taking
(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

Patient Disclaimer (Please Check One)

I am over the age of majority, and hereby represent to USDrugs.com, Inc., its officers, agents and employees ("USDrugs.com") that:

1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by USDrugs.com. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.
2. I understand that USDrugs.com is a U.S. pharmacy licensed to practice and practicing pharmacy in the State of Minnesota and that I am purchasing medications that have been approved for sale in the U.S. by the Food and Drug Administration. Title to my medications passes from USDrugs.com to me when my medications leave USDrugs.com's U.S. pharmacy. All agreements reached or contracts formed with USDrugs.com shall be deemed to be made in Minnesota, and the laws of the State of Minnesota shall have sole and exclusive jurisdiction over any dispute arising between myself and USDrugs.com.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES.

OR

I am the parent/legal guardian/power of attorney for the patient disclosed herein, am over the age of majority, have full authority to sign this Patient Form and have full authority to provide the above representations to USDrugs.com on the Patient's behalf.



Patient's Signature

Date (MM/DD/YY)

Mailing Address:
3505 8th St. South, Suite 9, Moorhead Minn, 56560-5108

Please use this form to submit your prescription(s), and send it back to us to complete your order.

Full Name _____
() _____
Phone Number _____ Order Number (if available) _____

Options 1: Contact My Doctor*

Physician's Name _____
Clinic Name _____
Street Address _____
City _____ State/Province _____ Country _____ Zip/Postal Code _____
() _____ () _____
Phone Number _____ Ext. _____ Fax Number _____

Options 2: Transfer From Another Pharmacy*

Pharmacy Name _____
Street Address _____
City _____ State/Province _____ Country _____ Zip/Postal Code _____
() _____ () _____
Phone Number _____ Ext. _____ Fax Number _____

Please list the medications you would like us to call your doctor for, or to transfer from another pharmacy.

Drug Name	Strength	Directions	Rx Number

* Contacting your doctor, and transferring from another pharmacy is only available to residents of the United States and Canada

Options 3: Mail Your Prescription

**ATTACH YOUR
PRESCRIPTION
HERE**

Please use a separate form for each written prescription

I will attach my prescription onto another page