

Order Form

PERSONAL INFORMATION

Male
 Female

Full Name (please print clearly) _____

Street Address _____

City _____ State _____ Country _____ Zip Code _____

Phone (Home) _____ Phone (Other) _____

Email _____ Birth date (MM/DD/YY) _____

Best time to be contacted _____

Please check if you are placing this order for a pet.

Cat Dog Others _____
(Please specify)

MEDICATIONS TO ORDER

Please enter the quantity and listed price for the medication(s) you wish to order, as obtained through our website or customer service center. An original prescription from your doctor's office is required (faxed, mailed, emailed or called in from your Doctor). **PRICING IS IN \$US DOLLARS.**

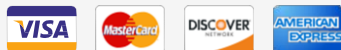
GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
SUB TOTAL :				
SHIPPING:				.00
TOTAL :				

PAYMENT OPTIONS

Pay by Credit Card

Personal Checking Account (Check or EFT) USA Only


Please call me to obtain my credit card information



Please note that in order to comply with the Payment Card Industry (PCI) Security Standard Council's requirements for the protection of your credit card information we are only able to accept your credit card information via telephone or through our secure online ordering system.

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 

Mailing Address :

Affordable Drugs
283 Danforth Ave
Suite 466
Toronto, Ontario
Canada M4K 1N2

FIRST TIME PATIENTS

(Please fill out this section if you are a first time patient, or to update your information.)

Your Physician

Primary Physician's Name _____

Clinic Name, Street Address _____

City _____ State _____ Country _____ Zip Code _____

Phone Number _____ Ext. _____ Fax Number _____

PRESCRIPTION SUBMISSION

(Please select one of the three options below.)

Option 1. Call My Doctor

Primary Physician's Name _____

Clinic Name, Street Address _____

City _____ State _____ Country _____ Zip Code _____

Phone Number _____ Ext. _____ Fax Number _____

Option 2. Transfer from another pharmacy

Pharmacy Name _____

Street Address _____

City _____ State _____ Country _____ Zip Code _____

Phone Number _____ Ext. _____ Fax Number _____

Option 3. Mail or Fax Your Prescriptions

Fax To :
1-800-281-1789

Mail To :
Affordable Drugs, 283 Danforth Ave, Suite
466, Toronto, Ontario, Canada M4K 1N2

ALLERGIES

Do you have any known drug allergies? Yes No

If yes, please enter the drug(s) you are allergic to:

Medication, OTC, Herbal Products You Are Currently Taking

(Only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY