

Medicine Tree Pharmacy

New Customer Form

Please print out this form,
complete it in dark colored ink and
fax it to 269-668-6802.

ph: 269.668.6801

fx: 269.668.6802

Medicine Tree Pharmacy
56109 Village Center Circle
Mattawan, MI 49071

1. Patient Information:

Patient Name _____ Date of Birth ___/___/___
Home Phone _____ Work Phone _____
Address _____
City _____ State _____ Zip _____
Allergies _____
Phone number where you can be reached _____

2. Prescription Info:

I have one or more new prescriptions to fill

Please send us a copy of your written prescription via fax so we can verify it with your doctor and start filling your order. Then mail us the original within 7 days for our files. If you do not have a written prescription yet, call your doctor and have him/her call or fax in the prescription for you.

Please transfer my prescription(s) from my old pharmacy.

Name of previous pharmacy _____
Old prescription# _____ Pharmacy phone _____

3. Retrieval Method:

Please check one of the following:

The prescription will be picked up

Please deliver. (Someone must be available to sign for the medication.)

Delivery address (if different from above):

Address: _____
City _____ Phone _____

4. Insurance Information:

Insurance Company _____
Social Security Number _____ PCN# or Bin# _____
Group # _____ ID/Member# _____

5. Billing Information:

Type of Credit Card: Visa MasterCard Discover

Name as it appears on the card _____ CVV2* _____

Credit Card # _____ Exp Date _____

* 3 digit code printed on the back of MasterCard, Visa and Discover Cards.

6. Authorization:

I authorize all prescriptions to be charged for amounts not covered by my
insurance plan to be billed to the above charge card number

Cardholder signature _____ Date _____