



Customer Order Form

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: F ___ M ___

Telephone Number: _____ Email: _____

Fax Number: _____

Billing Address:

Shipping Address:

Street: _____

City: _____

State/Province: _____

ZIP Code: _____

Country: _____

Product

Drug Name	Quantity	Cost	Total

Credit Card Info

Card Holder's name	
Card Number	
Expiration Date	
Verification Code	
Card Billing Address	

