PREMIUM RX
AFFORDABLE MEDICATION FOR ALL

Phone 1-833-313-3173

Fax 1-855-302-1818

Internet www.premiumrx.com
Email: info@premiumrx.com

Pharmacy Mailing Address: PremiumRX, 297 St Mary's Rd, Winnipeg MB, R2H 1J5, Canada

Patient Order Form

Personal Information

☐ Male ☐ Female

Full Name (please print clearly)

Street Address

City State Country Zip Code

Phone (home) Phone (other)

Email Address Birthdate (MM/DD/YY)

Best time to be contacted by our Pharmacist

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

It is mandatory that you have had a complete physical exam in the last 12 months. Has this been done? ☐ Yes ☐ No

Your medication will be packaged in child proof containers unless you decline. Do you decline child proof containers? ☐ Yes ☐ No

First Time Patients

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

Secondary Contact

Full Name of Secondary Contact

Relationship to You Phone Number

Your Physician

Primary Physician's name

Clinic Name, Stree Address

City State Country Zip Code

Phone Number Ext Fax Number

Known Allergies

Do you have any drug allergies? ☐ Yes ☐ No If yes please specify:

Current Medication, OTC, Herbal Products (list only the medications that you are NOT ordering)

MEDICATION	DOSAGE	FREQUENCY

Referral Program (complete to earn credits for yourself and the person who referred you)

Full Name of person who referred you Phone Number

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) **PRICING IN $US DOLLARS**

GENERIC OK?	MEDICATION	STRENGTH	QTY.	PRICE
			SHIPPING :	
☐ Check box if you do NOT want childproof caps.			TOTAL:	

Patient Agreement

I acknowledge and agree with Premium Health Solutions Inc as follows:

1). I am 18 years old or older in the jurisdiction that I reside.
2). I have fully and accurately disclosed my personal and medical information and consent to its use by the pharmacy and its employees and agents.
3). I authorize the pharmacy to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a Canadian Prescription for any prescription which I have sent the pharmacy; and (b) packaging my prescriptions and having them delivered to me.
4). Title to my medications passes from the pharmacy to me when they have left the pharmacy location. All agreements reached or contracts formed with the pharmacy shall be deemed to be made in the Province of Manitoba, Canada and the laws of the Province of Manitoba shall have sole and exclusive jurisdiction over any dispute arising between myself and the pharmacy, it's affiliates, parent company, related companies, subsidiaries, officers, directors and employees.
5). This agreement shall apply to every sale by the pharmacy to me and may not be altered unless in writing and signed by both the pharmacy and me.
6). I acknowledge that due to the nature of the products ordered, all sales are final and I cannot return products for refund or exchange.

By signing this agreement, I confirm I have read and understood these terms and that my information is true and correct. Furthermore, I agree that the terms herein are binding on me and my heirs, assigns, successors and personal representatives.

CALL TOLL-FREE: 1-833-313-3173 **FAX TOLL-FREE: 1-855-302-1818**

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Patient Signature

Date (mm/dd/yy)

Affiliate Box

Enter Affiliate Code, if applicable.

Payment Options

☐ Visa ☐ Mastercard ☐ Money Order ☐ Personal Cheque

Cardholder's Name

Cardholder's Address

City State Country Zip Code

Card Number Card Expiry

Note: payments by money order or check must be mailed to us BEFORE any medications are shipped.