# Fill Prescription Form

Please print out this form, complete
it in dark-colored ink, and fax it to
305.442.8185 or scan it and e-mail
it to: cgrx1@yahoo.com.
ph: 305.442.0211
ph: 1.877.442.8702
Coconut Grove Pharmacy
3001 SW 27th Ave.
Coconut Grove, Fl 33133

## 1. Patient Information:

Patient Name________________________________________
Phone (____)____________________________________
Date of Birth____/____/______

## 2. Prescription Info:

Please have you doctor call or fax us the prescription(s). If you have the prescription you may fax it to us so that we can verify it with your doctor and start filling the order immediately. Please be sure to give us the original prescription when we deliver the order or you pick it up in person at the pharmacy.

## 3. Retrieval Method:

Please check one of the following:

[ ] The prescription will be picked up.
[ ] Please deliver.
[ ] Please ship/mail.

Delivery/ Shipping Address (if different from address on file):

Address________________________________________________
City_________________________ State_____ Zip________
Phone (____)______________

## 4. Billing Information:

[ ] Bill card on file.

[ ] Bill new card below:

Type of Credit Card:

[ ] Visa [ ] Mastercard [ ] Discover [ ] Amex

Name as it appears on the card:

________________________________________________________

Credit Card #____________________________________________
Exp Date____/____/____
CVV2*_______________________________________________
*3-digit code printed on back of MasterCard, Visa, and Discover cards.
*4-digit code printed (NOT embossed) on front of American Express card.

## 5. Authorization:

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

Cardholder
Signature_______________________________________________
Date____/____/____