



Prescription Order Form

(for first-time or existing customers)

Complete this form, sign at bottom and send it to MedVantx along with your prescription(s) and payment. The address and fax number are at the top of this form. If paying by check, payment must be included with this form and received prior to processing order. If paying by credit card, please complete all required payment information to avoid delay in order processing.

Patient Contact Information

Name _____ Phone _____ Date of Birth ___/___/___

Address _____ Gender Male / Female

City _____ State _____ Zip _____

Shipping address (if different from above) _____

City _____ State _____ Zip _____

Patient Health Information

Doctor Name _____ Phone Number _____

Clinic Name _____ Fax Number _____

Health Conditions _____

Allergies _____

Current Medications - Drug Name, Dosage, and Frequency (i.e., lisinopril 10mg - 1 tab daily)

Payment Information - Complete payment method and required payment information to avoid delay in order processing.

Pay by Check - Payment must be included with this form and received prior to processing order. Make check payable to MedVantx.

Pay by Credit Card Visa MasterCard American Express Discover

Check this box if you would like us to keep your credit card information on file for faster processing in the future.

Credit Card # _____ Expiration Date _____

Name on Card _____

By signing this form, I hereby authorize that:

1. The information provided on this form, to the best of my knowledge, is complete and accurate.
2. MedVantx may act as my agent to obtain and ship product(s) to the listed address.
3. MedVantx may reserve the right to refuse service and shipment of their product(s) based on any intended abuse or illegal distribution thereof.

Authorization to Release and Disclose Medical Information: I authorize MedVantx and other companies MedVantx uses to administer the following:

1. Manage and handle records of all prescriptions for the product(s) I receive.
2. Use information provided and contact my healthcare provider(s) or me for the purpose of fulfilling services for all records within MedVantx.

Signature _____ Date _____