



New Prescription Order

Below is the new prescription form. Please be sure to send this along with the written prescription from your doctor. You'll need to mail it to us along with a completed print out of this "Patient Enrollment" form.

Mail Address:

**PPS-Postal Prescription Services
P.O. Box 2718
Portland, OR 97208-2718**

Mail-in Form

STEP 1: Patient Information

Patient Name: _____

First Name

Last Name

Sex: ___Male ___Female

Birth Date: ___/___/___ SSN# ___-___-___

Drug Allergies: ___None

Codeine ___

Penicillin ___

Aspirin ___

Sulfa ___

Other(s): _____

STEP 2: Shipping/Billing Address Information

Address Line 1: _____

Address Line 2: _____

City/State/Zip: _____

Home Phone Number: () _____

Daytime Phone Number: () _____

E-mail Address(es): _____

Please include me in future E-mail promotions. ___Yes ___No

STEP 3: Insurance Information

Insurance Company Name: _____

Employer's Name: _____

Insured Name: _____

Insured I.D. Number: _____

STEP 4: Payment Information

Credit Card Information

Payment Type: Visa MasterCard American Express Discover

Credit Card Number: _____(ie: nnnn-nnnn-nnnn-nnnn)

Expiration Date: ____/____(ie: MM/YYYY)

Other payment methods

Check Amount \$ _____ Money Order \$ _____