

DISCOUNT GENERICS
P.O. BOX 308
HALLANDALE, FL 33008
TOLL FREE 1-800-456-1026
FAX 1-954-454-4042
www.DiscountGenerics.us

CUSTOMER INFORMATION

DG# _____

Primary Address (Please Print Clearly)

Your Full Name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Home Telephone: (____) _____ Work Telephone: (____) _____

Cell: (____) _____ Fax Number: (____) _____ E-mail: _____

Age: ____ Weight: ____ Height: ____ Sex: Male__ Female__ Date of Birth: Month__ Day__ Year__

Where did you hear about us? _____

Primary Physician Information

First Name: _____ Last Name: _____

Street: _____ City: _____ State: _____

Zip: _____ Phone: (____) _____ Fax: (____) _____

I have been to my doctor in the last 12 months and had a physical exam. **Yes**__ **No**__

I am ordering these prescriptions per my doctor's recommendation and I have made my own decision to order these medications. If I have any side effects from these medications, I will immediately contact my doctor. I accept responsibility to check my order upon receiving it to make sure it is correct.

Yes__ **No**__

Allergy Information

Do you have any DRUG ALLERGIES? YES__ NO__ If yes, list and describe reaction below:

Do You Want Child Proof Containers: Yes__ No__

Prescriptions I am ordering (all orders are shipped with a 90 day supply)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

I agree that all of the above customer information is 100% correct and that I am purchasing these medications only for myself and if there is any change in my physical well being, I will immediately inform Discount Generics, Inc. **Yes**_____

Payment Information

Credit Card: Visa__ MasterCard__ Credit Card Number: _____

Cardholder's Name: _____ Expiration Date: _____

Signature: _____