PraxisRx™

MEMBER INFORMATION

(844) 553-7500 | WWW.PRAXISRX.COM

Mail To:
Praxis Rx
5455 West Waters Avenue,
Suite 214
Tampa, FL 33634

CARDHOLDER ID# (REFER TO ID CARD)

GROUP # (REFER TO ID CARD IF APPLICABLE)

LAST NAME OF CARDHOLDER

FIRST NAME OF CARDHOLDER

DELIVERY ADDRESS (STREET AND APARTMENT NUMBER)

CITY

STATE

ZIP CODE

EMAIL ADDRESS

DAYTIME PHONE NUMBER

DATE OF BIRTH (MM/DD/YYYY)

GENDER ☐ M ☐ F

Drug Allergies:

☐ No Known Allergy ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa
☐ Aspirin ☐ Erythromycin ☐ Other _____

Health Conditions:

☐ Arthritis ☐ Diabetes ☐ Heart Condition ☐ High Cholesterol ☐ Ulcer
☐ Asthma ☐ Epilepsy ☐ High Blood Pressure ☐ Thyroid
☐ Depression ☐ Glaucoma ☐ Other _____

List any OTC, herbal, or other medications you take regularly: _____

PAYMENT OPTIONS

Payment is due with each order. **Do not send cash.** If you use a credit card for payment, PraxisRx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Credit Card Type (Our preferred payment method for faster service)

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ Use credit card on file ☐ Please place credit card on file for future orders

ACCOUNT NUMBER

EXPIRATION DATE

SECURITY CODE

☐ Check or money order enclosed. Cardholder Signature: _____ Date: _____

Notes to Pharmacy:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to PraxisRx Pharmacy.

Signature: _____ Date: _____

To refuse generics check here (□), AND sign and date. PraxisRx Pharmacy substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products. "I understand that I have the right to refuse generic medications. I understand this may result in a high cost to me, that I am responsible for payment, and that the drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept the conditions."

Signature: _____ Date: _____