



MedicDiscount Inc.

26331 Asuncion Drive, Punta Gorda, FL 33983
Phone: 1-941-764-0030 Fax: 1-775-417-4169

General Information:

MedicDiscount Inc. would like to thank you for giving us the opportunity to serve you. We consider serving your pharmacy needs to be both an honor and a trust. To provide you with the very best of care, we must ask for some basic information regarding your medical history. Please take the time to read and understand all of the following information and answer each question to the best of your knowledge. If you have any questions regarding any of this information, please contact us.

1. We do not fill prescriptions for controlled substances such as benzodiazepines, narcotics or amphetamines.
2. We do not ship drugs that require refrigeration.
3. Some drugs available in the United States may not be available in Canada and, therefore, are not available from us.
4. Laws governing the sale of drugs in Manitoba, Canada, require the substitution of brand name drugs with generic equivalents. These generic versions are deemed therapeutically identical to the brand name drug by experts. We, therefore, make generic substitutions where appropriate. This will help to save you even more money on your purchases.

Please remember to specify in the space on the Order Form.

5. All prescriptions must be co-signed by a doctor licenced in Canada. Your current and accurate medical information will assist the Canadian doctor in this task. He/she may need to contact yourself or your regular doctor.
6. Laws restrict us to shipping not more than a 3 months supply of medications.
7. Before shipping any medications to you, you must have had a physical within the last year.
8. Pharmacy laws in Manitoba, Canada prohibit us from accepting any medication(s) for return or refund. All sales are final.
9. We require you to have taken a medication for at least 30 days before ordering the same drug from us.
10. All dollar amounts quoted are in US currency.
11. We accept MasterCard, Visa and money orders.
12. Our hours of operation are Monday to Friday, 9:00 AM to 5:00 PM Central time.
13. Since your credit card will be debited through a Canadian bank, be sure to check that there are no restrictions on your card preventing this. This could lead to delays in your order processing.

How To Order:

1. Complete all six (6) forms by answering the questions.
2. Fax or mail the completed forms along with your prescription(s) to the number or address above. We will then verify your prescription(s) with our Medical Team (Doctor, Pharmacists and Technicians). Your order will be processed and shipped within approximately 36 hours from being received.
3. Simply wait. Your order should arrive at your home in about 7 to 10 working days. If you have any questions, feel free to contact us between 9:00 AM and 5:00 PM Central time, Monday to Friday.

Patient's Name

Patient's Signature



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Medical History:

Family Medical History:

Do you have a family history of any of the following conditions? If you answer yes, please describe them briefly in the space provided.

Medical Condition	No	Yes	Description
Heart disease			
Kidney disease			
Liver disease			
Lung disease			
Eye disease			

Your Medical History:

Do you currently suffer from any of the following conditions? If you answer yes, please describe them briefly in the space provided.

Medical Condition	No	Yes	Description
Heart (heart failure, heart attack)			
Kidney			
Liver			
Lung (asthma, emphysema)			
Eye (glaucoma)			
Cardiovascular (high or low blood pressure)			
Cancer			
Emotional			
Thyroid			
Immunological (tissue healing)			
Blood (bleeding disorder)			
Nutritional (electrolyte deficiencies)			
Other (please specify)			

Patient's Name _____ Signature _____



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Drug and Allergy History:

Please Print clearly.

Drug History:

Please list all the medications you are currently taking and the condition each is used to treat.

Name of Drug	Strength	How Long on Med	Medical Condition (if known)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Drug Allergies:

If you have suffered an allergic reaction to any drug, please list them below along with the type of reaction experienced.

Drug	Reaction

Do you smoke? No___ Yes___ How much?_____

Do you drink alcoholic beverages? No___ Yes___ How much?_____

Do you drink caffeinated beverages? No___ Yes___ How much?_____

Have you had any vaccinations? No___ Yes___ List_____

When did you last visit your Doctor? _____

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Patient Information:

Please print clearly

Surname

Date of Birth (Year/Month/Day)

Middle Name

Weight

First Name

Sex

Street Address

Doctor's Name

City

Doctor's Address

State

Zip

Doctor's Phone

Email Address

Type of Credit Card (MasterCard or Visa)

Phone (Home)

Name Appearance on Card

Phone (Work)

Card Number

Age

Card Expiration Date

Patient's Full Name

Patient's Signature

Please note that all prescriptions will be dispensed and shipped by RiverCity Meds and as such RiverCity Meds will be the name that appears on your credit card statement.



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Order Form:

Please print clearly.

Brand Name of Medication Requested	Medical Condition (if known)	Strength	Quantity	Price
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Shipping and Handling				\$12.00
TOTAL (all amounts are in US dollars)				

IMPORTANT: I accept generic substitutions for name brand medications. YES _____ NO _____

I would like counseling from a pharmacist regarding the use of my medications. YES _____ NO _____

Name of Medication Currently Being Taken	Medical Condition For Which Medication is Taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Patient's Name

Patient's Signature