Hallandale PHARMACY
a division of Pharmcore, Inc.

Please Fax to:
954-381-8164 (general fax#)

TODAY'S DATE: _____

Patient Name:		**Date of Birth D/M/Y :**	
Address:			
City:	**State:**	**Zipcode:**	
Phone No (H):		**Phone No. (W):**	
Allergies:			

HOW	**Next Day Air ($30)** ☐	**Fed-Ex 2nd Day Air ($18)** ☐	**Fed-Ex Ground ($12)** ☐	**Fed-Ex Sat ($45)** ☐			
WHERE	**Ship to Clinic** ☐	**Ship to Patient** ☐	**Patient Pick-Up** ☐				
WHO	**Charge Clinic (card on file/below)** ☐	**Charge Patient (card provided below)** ☐					

PLEASE BE INFORMED THAT ALL ORDERS ARE SHIPPED WITH SIGNATURE REQUEST. IF YOU WISH TO DECLINE, YOU WILL ASSUME ALL RESPONSIBILITY FOR THE PACKAGE IN THE EVENT THAT IT GETS LOST, STOLEN OR DAMAGED.

TO DECLINE SIGNATURE REQUEST PLEASE CHECK BOX: ☐

Visa ☐	**Master-Card** ☐	**Amex** ☐	**Discover** ☐
Name On Credit Card:			
Credit Card #:	**Ex Date:**	**CVV #:**	
Billing Zip-Code:	**Signature:**		

Description	Size	Quantity	Directions

DOCTOR (please print):		**SIGNATURE:**
DEA #:		**STATE #:**
PHONE #:		**FAX #:**
ADDRESS:		
CITY:	**STATE:**	**ZIP-CODE:**