

Veterinary Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

Complete to submit pet's enrollment

Pet	Date: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Pet's Name: _____ Species: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Phone Number: _____
	DOB: _____ Weight: _____ lbs (circle one) Recorded Date: _____
	Caregiver: _____ Allergies: _____
	Diagnosis: _____

PRESCRIPTION	Medication	Strength	Directions	Quantity	Refills

Prescriber	Date Shipment Needed: _____ Ship to: _____ Home Address _____ Physician/Clinic _____
	Physician's Name : _____ Office Contact Name _____
	Phone #: _____ Fax #: _____ DEA #: _____
	Office Address: _____ City: _____ State: _____ Zip: _____
	Physician's Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.