NEW PATIENT ORDER FORM

Phone: 1-888-222-3505
Fax: 1-888–896-7966

Email: info@greatnorthdrugs.com
Website: greatnorthdrugs.com

Mailing Address: 105-1700 Corydon Ave., Winnipeg, MB, Canada R3N0K1

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105-1700 Corydon Ave.
Winnipeg, MB, Canada R3N0K1

PERSONAL INFORMATION

Full Name (please print clearly) Male Female

Street Address

City State Country Zip Code

Phone (Home) Phone (Other)

Email Birth date (MM/DD/YY)

Best time to be contacted

Please check if you are placing this order for a pet.

Cat Dog Others (Please specify)

Smoker Non-Smoker Weight: Height:

Pregnant Nursing?

MEDICATIONS TO ORDER

Please enter the quantity and listed price for the medication(s) you wish to order, as obtained through our website or customer service center. An original prescription from your doctors office is required (faxed, mailed, emailed or called in from your Doctor). All orders are placed using USD currency.

GENERIC EQUIVALENT OK?	MEDICATION	STRENGTH	QTY	PRICE
			SUB TOTAL:	
			SHIPPING:	
			TOTAL:	

ALLERGIES

Do you have any severe allergies? Yes No

Please list the following severe allergies:

Are you currently taking any vitamins, herbs or minerals? Yes No

Please list the following:

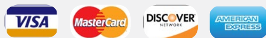
Do you have any medical condition or history our Pharmacy department should be aware about?

Do you currently taking other medications aside from what you are looking to place an order for?

PAYMENT OPTIONS

Pay By Credit Card

Please call me to obtain my credit card information



Please note that in order to comply with the Payment Card Industry (PCI) Security Standard Council's requirements for the protection of your credit card information we are only able to accept your credit card information via telephone or through our secure online ordering system.

Personal Checking Account (Check or EFT)

USA Only

Use my check information "on file"

I will send a VOIDED check by:

Fax Email Mail

I will make a payment by check, and mail it to →

Mailing Address:

105-1700 Corydon Ave.
Winnipeg, MB,
Canada R3N0K1

FIRST TIME PATIENTS

(Please fill out this section if you are a first time patient, or to update your information.)

Your Physician

Primary Physician's Name

Clinic Name, Street Address

City State Country Zip Code

Phone Number Ext. Fax Number

PRESCRIPTION SUBMISSION

(Please select one of the three options below.)

Option 1. Contact My Doctor's office via fax

Note: We will attempt to contact your doctor's office via fax up to 4 times as majority of the doctor's offices in the USA prefer to respond to prescription requests submitted via fax. This allows us to avoid any additional delays. However, you contacting your doctor's office directly to have the prescription sent to us via fax is preferred.

Option 2. Contact Local Pharmacy for Prescription Transfer request.

Note: We will attempt to contact your local pharmacy via fax up to 4 times.

Option 3. Mail or Fax Your Prescriptions

Fax: 1-888–896-7966

Mailing Address:
105-1700 Corydon Ave.
Winnipeg, MB, Canada R3N0K1

Please use 3 forever stamps/$1.15 in postage as you are sending your document via international mail. Failure to do so may result in your mail being lost. Keep in mind it may take 7-10 business days to receive international mail.