207 E Main St, Remington, VA 22734 ● Toll Free: 800.675.8041 ● Ph: 540.439.3247 ● Fax: 540.439.9822 ● Email: info@remingtondrug.com

Sildenafil Patient Order Form

PERSONAL INFORMATION

_____ ☐ M ☐ F

Full Name (please print clearly)

_____

Street Address City State Zip

(_____)_____ (_____)_____ (_____)_____

Phone (Home) Phone (Cell) Phone (Work)

_____ _____

Email Birthdate (MM/DD/YYYY)

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website, advertisement, customer service team, or pharmacy team. **An original prescription from your doctor's office is required** (mailed, called / e-script / faxed in from your Doctor).

MEDICATION	STRENGTH	QUANTITY	PRICE ($2 per Tablet**)
SILDENAFIL	20MG		
FREE SHIPPING FOR 3 MONTH SUPPLY OR MORE, $6 FOR ALL OTHERS			
☐ Check box if you do NOT want childproof caps		**TOTAL:**	

**PRICING IN $US DOLLARS

YOUR PHYSICIAN (Please fill out physician information if you're a first time patient, or to update your information)

_____

Primary Physician Name Clinic Name

_____

Street Address City State Zip

(_____)_____ (_____)_____

Phone Number Ext Fax Number