New Account Physician Form

Date: _____ /_____ / _____

Practice Name: _____ **Main Contact Person:** _____

Medical Director: _____

Doctor Name: _____

DEA# _____ **NPI#** _____

Licensee Signature: _____ Date: _____

Doctor Name: _____

DEA# _____ **NPI#** _____

Licensee Signature: _____ Date: _____

Doctor Name: _____

DEA# _____ **NPI#** _____

Licensee Signature: _____ Date: _____

Mailing Address: _____

Shipping Address: _____

Phone: _____ /_____ /_____ **Fax:** _____ /_____ /_____

E-Mail Address: _____

Please fax a current copy of medical license.

I authorize **Texas Star Pharmacy** to process payments on the following credit card:

Card # _____ (You may call us with #) Exp. Date: _____

Card Holder Signature: _____ Date: _____

Person(s) authorized to purchase products on this account for your practice:

_____

How did you find out about Texas Star Pharmacy:

___ Referral (_____) ___ Email ___ Website ___ Mailer ___ Fax ___ Other

Primary Compounding Areas of Interest: _____

Please allow 2-3 days for your compound. We do not ship on Fridays.

Salesperson: _____

PLEASE FAX COMPLETED FORM TO: (972) 519-8477

Phone: 972-519-8475 • **Fax:** 972-519-8477
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