

## New prescription intake form

### Patient information

First name	<input type="text"/>
Last name	<input type="text"/>
C/O(if applicable)	<input type="text"/>
Street address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Telephone number(s)	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Email(optional)	<input type="text"/>
Date of birth	<input type="text"/>
Allergies	<input type="text"/>

Insurance ID number	<input type="text"/>
Person number	<input type="text"/>
Group number	<input type="text"/>
Prescription insurance phone (For regular prescriptions)	<input type="text"/>

### Physician information

Physician name	<input type="text"/>
Street address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Phone number	<input type="text"/>
Fax number	<input type="text"/>

**Billing information**

(If different from shipping address)

First name	<input type="text"/>
Last name	<input type="text"/>
Street address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Phone number	<input type="text"/>
Credit card number	<input type="text"/>
Credit card type	<input type="text"/>
Expiration date	<input type="text"/>
Additional information	<input type="text"/>