Generic Mail Order Form

HealthWarehouse

Patient Shipping Information:

Name _____

Address _____

City/State/Zip_____

Phone # _____

Date of Birth _____

Gender _____

ID # _____

Allergies: _____

_____

_____

Medical Conditions: _____

_____

_____

Other Medications: _____

_____

_____

Place Prescription Here

Place Prescription Here

Doctor's Name: _____

Doctor's Telephone No.:_____

There are two ways to place your order:

1. **Mail**: HealthWarehouse.com, Inc.
   100 Commerce Boulevard
   Cincinnati, Ohio 45140
2. **Fax:** You or your doctor may fax these documents to **866-821-1284**.