LAST NAME FIRST NAME

STREET

CITY STATE ZIP

CONTACT PHONE EMAIL

METHOD OF PAYMENT

Make checks payable to Davis Drugs OR ☐ MasterCard ☐ Visa ☐ Discover

NAME ON CARD

CARD NUMBER EXP. DATE

REFILL PRESCRIPTION NAME

REFILL PRESCRIPTION NAME

REFILL PRESCRIPTION NAME

May we contact your physician for refill authorization yes ☐ no ☐

Instructions:

option 1: print, fill out, and fax the form to the preferred location.

option 2: complete the form and email it to your preferred location.

option 3: print, fill out and mail to your preferred location.

If this is a new prescription, please call your location after you have sent the completed form. Please allow up to 24 hours for processing.