



**Parkview
Compounding
Pharmacy**

**Please complete this form
and mail or fax it to:**

866-895-8571 (FAX)

or scan and email to:

parkviewrx@gmail.com

800-605-0166 Phone

866-895-8571 Fax

Parkview

Compounding

Pharmacy

8283 Grove Avenue Ste 105

Rancho Cucamonga, CA

91730

***Between Foothill & Arrow
Hwy.***

New Rx **Transfer Rx** **Refill Rx**

1. Patient Information:

Name _____ Date of Birth _____

Home Phone (____) _____ Work Phone (____) _____

Address _____

City _____ State ____ Zip _____

Allergies _____

Phone number where you can be reached (____) _____

2. Refill / Retrieval Method:

Please check one of the following:

Please use AUTO-FILL (Healthminder) for my prescriptions

I will generally pick up my prescriptions

Please deliver. (Someone must be available to sign for the medication.)

Please ship/mail. (Someone must be available to sign for the medication.)

Delivery/Shipping Address (if different from above):

Address _____

City _____ State ____ Zip _____ Ph. (____) _____

3. Insurance Information:

Please fax a copy of your insurance card, if available.

Insurance Company _____

Social Security # _____ PCN# or BIN# _____

Group ID# _____ ID/Member# _____

4. Billing Information:

Type of Credit Card Visa MC Discover Amex

Name (as it appears on the card) _____ Code# _____

Credit card # _____ Exp. Date _____

I authorize all prescriptions charged for amounts not covered by my insurance plan to be billed to the above charge card number

Cardholder signature _____ Date _____

