

Details

Please tick one

MASTERCARD VISA CHEQUE AMEX DINERS CLUB MONEY ORDER JBC

Card Number:

Expiry Date:

Amex ID:

Signature

Only signed orders can be accepted. Order will be sent once funds have been cleared.

**The Following details are only required
If you are ordering prescription medication.**

Patient Details (if different than above)

(Only required if you are ordering prescriptions medication)

Name:

Date of birth: Sex: M F

Health Care Card/ Pension Card No:

Expiry Date:

Medical Practitioner

(Only required if you are ordering prescription medication)

Doctor's Name:

Address: Post Code:

Medicare Name:

Medicare No:

Medicare Sub. No.: – Subscribe before me

Medicare Expiry:

Concession Card Holders (optional)

Health care No.:

Medicare Expiry:

Pensioners

Pension No.:

Pension Expiry:

Safety Net (optional)

Safety Net No:

Do you have any of the following drug allergies?
(Only required if you are ordering prescription medication)
Please tick the appropriate box (ex) below:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> No Chronic Conditions | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulpha |
| <input type="checkbox"/> Tetracycline | |
| <input type="checkbox"/> Other drug allergies | |

Do you have any of the following medical conditions?
(Only required if you are ordering prescription medication)

- | | |
|--|--|
| <input type="checkbox"/> No Chronic Conditions | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid |

Other drug allergies:

Other medical conditions:

Prescribed Medicines

(Only required if you are ordering prescription medication)

- Have you had this medication before
 Not regularly taking any prescribed medicines - or -
 Regularly taking medicine(s) that have been prescribed by a doctor or dentist.

The names of these medicines are:

Non Prescription & Other Medicines

(Only required if you are ordering prescription medication)

Not regularly taking any non-prescription medicines – or - Regularly taking medicine(s) obtained without prescription (Including from a pharmacy, supermarket, health food shop etc) eg. For headache, heartburn, etc. (including herbal and complementary medicines.)

The names of these medicines are:

Have you had this medicine before?

Yes No

Comments

Would you like us to substitute a less expensive equivalent medication for a brand name medication if available and if your doctor permits?

Yes No

Do you require a receipt for your private health fund?

Yes No

Repeat Prescriptions

Would you like us pharmacy to keep you repeat prescription?

Yes No

Privacy: We protect your information against unauthorized access or release. Your information is only accessible by the Pharmacy who processes your prescription. We will not give, sell, rent, or loan any identifiable personal information to any third party, unless you have authorized us to or we are legally required to so.