SmartMeds Pharmacy

Patient Name | First Name | Last Name

Date of Birth | Day | Month | Year

Rx Number(s) For Refill
(for existing clients)

1	2	3
4	5	6
7	8	9

Delivery OR Pick Up? ☐ Delivery ☐ Pick Up What Time

If Marked Yes For Delivery,
Please Indicate Address For Driver

Address Line 1

Address Line 2

City | Zip | Phone

Is this New Rx ? IF SO PLEASE CONTACT THE PHARMACY AT 905-336-8672

Patient (s) Name

1	2
3	4

Home Address

Address Line 1

Address Line 2

City | Zip

Home Phone | Work Phone

Pharmacy Where
Meds Are Currently Filled: Name | Phone

Allergies?

Vials
Or Smartmeds Packaging: ☐ Vials ☐ Weekly Packaging:

Drug Plan? ☐ Yes ☐ No

If Marked Yes

Health Card No. (For Senior)

Private Plan Name

Private Plan Card Number