

PRESCRIPTION

NEW MEDICAL PROVIDER INTAKE FORM

PRACTICE / COMPANY

NAME:	ADDRESS:	CITY, STATE:	DATE of BIRTH (Month / Day)
		_____ / _____	
EMAIL:	TELEPHONE:		
WEB SITE URL:			

PROVIDER 1

PROVIDER:	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email

PROVIDER 2

PROVIDER:	PHONE	NPI #	DEA #
OFFICE MANAGER	PHONE	OFFICE FAX	OFFICE Email

QUESTIONS

1. Are the medications ordered going to be paid by?	<input type="checkbox"/> Company	<input type="checkbox"/> Patient
2. We are shipping the order to:	<input type="checkbox"/> Provider	<input type="checkbox"/> Patient
3. Is MILLERS permitted to contact patient?	<input type="checkbox"/> Only Provider	<input type="checkbox"/> MILLERS may contact
4. Do you require signature of patient for shipments of controlled substances (charge applies)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Did you approve the pricing sheet provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. On controlled substance, You agree that you will do PMP and other appropriate background checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. You agree that you have represented to MILLERS that it can rely on such information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PAYMENT INFORMATION

NAME:			
BILLING ADDRESS: (If different than mailing address)			
TYPE:	<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
CARD #	EXPIRATION DATE:		SECURITY CODE:

ACH TRANSACTION

BANK:	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS ABA	ROUTING #	ACCOUNT #
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AGREED PRICING/NOTES

PROVIDER:	PHONE	EMAIL:
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SIGNATURE:

DATE (Month / Day / Year)

_____ / _____ / _____

Milles of Wyckoff, 678 Wyckoff Ave., Wyckoff, NJ 07481