





NEW PATIENT ORDER FORM (1 of 2)

MAILING ADDRESS: 201 – 7350 King George Blvd. Surrey, BC V3W 5A5

Personal Information			Mala C Familia C
First Name (Please print clearly)	Last Name		Male Female
Please check if you are placing this	s order for a pet. Cat Oog O	Other Pet Na	ame
Street Address			
City	State/Province	Country	Zip/Post Code
Phone Number	Daytime Phone Number	Fax Number	Date of Birth (MM/DD/YYYY)
When it is time to be contacted t	o remind you of future refills noti	fy me by: Phone Email	Text Message
Best time to be contacted	Email		
Secondary Contact			
I authorize the following person	n to communicate on my behalf ful	ly in all matters:	
First Name of Secondary Contact	t (Please print clearly)	Last Name of Secondary Contac	:t
Relationship		Phone Number	
Power of Attorney			
I of sound min	d and body, being over the age of	maiority, and recognizing that this au	ithorization relates to my personal health
			epresentative for Kama Helath to receive ation as well as to place an order on my
behalf. I understand that I am resp	onsible for any charges on my acco	ount for orders placed by my authoriz	zed representativeInitial here.
Patient Authorization (Plea	se Check One)		
		al centre in White Rock, British Colum	bia, Canada, which facilitates the access of
			ailable. The following terms and conditions
		r) [partnered with KamaHealth.ca] and r. The Patient herein represents to the	the individual (the "Patient") regarding the Pharmacy that.
"I am over the age of majority,		. The radioner nor our represents to the	. Harriacy triat,
_		ersonal health information and cons	ent to its use by the Pharmacy. I have had
		do not require a physical examination	
2. I understand that all Products s consistent with the laws of that jur		armacy operating within a unique ir	nternational jurisdiction and in a manner
3. I authorize and appoint the Phari	macy, as my attorney and agent, to		to act on my behalf as if I were personally
			n which I have sent the Pharmacy; and (b) I to: collecting and using my personal and
			to a licensed physician if required for the
			ny time and shall continue until I revoke it
			ne jurisdiction of the Pharmacy, and that I ny medications passes from the Pharmacy
to me in the jurisdiction of the Pha	rmacy when my medications leave	the Pharmacy. All agreements reache	ed or contracts formed with the Pharmacy
			y shall govern all transactions, and I attorn any dispute arising between me and the
Pharmacy, its affiliates, officers and		sole and exclusive jurisdiction over t	any dispute unsing serveen me and me
OR			
		erein, am over the age of majority, and have	e full authority to sign for and provide the above
representations to the Pharmacy on the I HAVE READ AND UNDERSTAND THESE		BE BINDING UPON ME AND MY ASSIGNS	i, HEIRS AND PERSONAL REPRESENTATIVES."
→ SIGNATURE:			DATE:/
_ JIJIII III.			



Credit Card Number





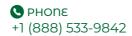


CVV Code

NEW PATIENT ORDER FORM (2 c	of 2) MAILING	ADDRESS: 201 – 7350 King George	e Blvd. Surrey, BC	V3W 5A5	
Current Medical Information					
Height (Feet), (Inches)	, Weight (Pounds)	, Smoking Yes No , Curre	ently or trying to g	et pregnant	Yes \(\) No \(\)
Do you have any known drug alle	ergies? Yes No If yes	, what are they:			
Medication, OTC, Herbal Pr	roducts You Are Current	ly Taking			
(only list medications you are no					
MEDICATION			DC	DSAGE I	FREQUENCY
Medications Order For medication(s) that you wish to	order, please enter the quanti	ty, and listed price, as obtained thro	ough our website o	r customer se	rvice center. Ar
		, emailed or called in from your Doc			
GENERIC OK?	MEDICATION		STRENGTH C	QUANTITY	PRICE
				SHIPPING TOTAL	FREE
				701712	
Payment Options (Please S	select One)				
1. (ACH) Direct Bank Withdraw		2. PERSONAL CHEQUE			
I will fax or email a void chequinfo@kamahealth.ca	ie to one of the following:	 Please make cheques pay Kama Health 	able to Kama Hea	lth and send	to:
Fax: +1 (855) 710-6444		201 – 7350 King George I	Blvd.		
OR		Surrey, BC V3W 5A5			
3. CREDIT CARD	VISA	MASTERCARD	(Sorry N	IO Amex)	
S. CREBIT CITE	Visit	MASTERIORIES	(3011), 10	Ο Τιπιέλη	
Cardholder's Details					
First Name (Please print clearly)		Last Name			
Street Address					
City	Province	Country	Post Cod	e	

Expiry Date (MM/YY)









PRESCRIPTION SUBMISSION

Please use this form to submit your p	rescription(s), and	send it back to t	us to complete your order.	
First Name (Please print clearly)	Last Name		Phone Number	
Patient ID		Order ID		
Your Physician				
Primary Physician's Name		Clinic Name		
Street Address				
City Province		Country	Post Code	
Phone Number	Ext		Fax Number	
Email:				
Option 1 (FASTEST) Email or Fax a c Scan or use your camera (smartphone) to ta of your original prescriptions, then email the	ke a clear picture	Sending	il originals. the scan will allow your order to ail your original prescription to:	continue processing
To: info@kamahealth.com		Kama Health		
Subject: Prescription(s) for (type your name)		201 – 7350 King George Blvd.		
<i>OR</i> Fax: +1 (855) 710-6444		Surrey, B	C V3W 5A5	
Option 2 Contact Your Doctor				
Please list the prescriptions you wou	ld like us to reque	st from your Doc	tor for your order.	
DRUG NAME	STRENGTH		DIRECTIONS	RX NUMBER

DRUG NAME	STRENGTH	DIRECTIONS	RX NUMBER