

PRESCRIPTION ORDER FORM FOR TENS / EMS / INTERFERENTIAL UNITS

Please print out this form, complete the top portion, have your Health Care Provider (Medical Doctor, Chiropractor, Podiatrist, Physical Therapist, Doctor of Osteopathy, Nurse Practitioner, Dentist or Doctor of Acupuncture) sign it and mail or fax it to us.

This form is required when the shipping address is within United States ONLY!!

(Please Print)

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone No: _____ Evening Phone No: _____

Fax No: _____ E mail: _____

Unit Prescribed: _____

Signature: _____

Name of your licensed health care practitioner: _____

License Number: _____

Doctor's Address: _____

City _____ State _____ Zip _____

Doctor's Signature: _____ Date: _____

Please complete and mail/fax/email to:

Aries Medical Supply.com
4464 Lone Tree Way # 196
Antioch Ca 94531
925-476-8552 Phone
641-795-0544 Fax
sales@ariesms.com