



Uniform New Jersey Prescription Blanks Order Form

Tel: 201-670-9797 x4 • Fax: 201-670-9798
rx@ridgewoodpress.com

CUSTOMER INFORMATION/BILLING

PRACTICE NAME _____

STREET ADDRESS (REQUIRED FOR UPS SHIPMENT) CITY, STATE AND ZIP _____

PHONE NUMBER (INCLUDE AREA CODE) _____ FAX NUMBER (INCLUDE AREA CODE) _____

NAME OF PURCHASER _____ EMAIL ADDRESS _____

OFFICE CONTACT PERSON _____ EMAIL ADDRESS _____ TEL (INCLUDE AREA CODE) _____

Ordering Instructions:

1. Per state requirements, all orders and reorders for Uniform New Jersey Prescription Blanks must be submitted in writing via mail, fax, and/or email.
2. Use one Order Form per prescription order. Multiple prescriber names and one address may be printed on the front of each prescription. Additional addresses may be printed on the back for an additional cost.
3. The address used for shipping must match with the listing of authorized prescribers and health care facilities on file with the licensing board.
4. License numbers **must be** provided for each prescriber facility.
5. The signature of each authorized prescriber or health care facility representative **must be** provided with each order.
6. Payment via credit card only. Completed credit card form with signature must accompany this order or it will not be processed.

ORDERING INFORMATION: Please Check One

Healthcare

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____ DEA # _____

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription
THEY, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PERMISSIBLE BY LAW

MD, DO, DDS, DMD, DPM, DVM,
VMD, MVSc

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____ DEA # _____

DELEGATED PHYSICIAN SUPERVISOR

LICENSE # _____ TEL # _____

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

PRN
 JPR

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription
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Physician Assistant

State of New Jersey
PRESCRIPTION BLANK

CERTIFICATION # _____ DEA # _____

COLLABORATING PHYSICIAN

NAME _____ LICENSE # _____

(Enter Address and Phone Number only if different from above)

ADDRESS _____ PHONE # _____

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription
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Advanced Practice Nurse

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____ DEA # _____

AFFILIATED PHYSICIAN

NAME _____ LICENSE # _____

TELEPHONE # _____

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

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Certified Nurse Midwife

Healthcare

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____

PRINT ABOVE: NAME AND TITLE OF PRESCRIBER AND, IF APPLICABLE, COLLABORATIVE PHYSICIAN

CHECK BY: APR DM PA JPR PRESCRIBER COLLABORATIVE PHYSICIAN

LICENSE CERTIFICATE IN REGISTRATION # _____

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

NOT VALID FOR CONTROLLED SUBSTANCES IF ISSUED BY AN OPTOMETRIST

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

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Health Care Facility

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____

VALID ONLY FOR PRESCRIPTION EYEWEAR

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

	SPHERE	CYLINDER	AXIS	PRISM
OD				
OS				
ADD			P.D. _____ / _____	
ADD			REMARKS:	

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription
THEY, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PERMISSIBLE BY LAW

For Exclusive Use When
Prescribing Eyewear

State of New Jersey
PRESCRIPTION BLANK

LICENSE # _____ DEA # _____

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

NOT VALID FOR SCHEDULE II CONTROLLED SUBSTANCES, VALID FOR TOPICAL PHARMACEUTICAL AGENTS (IF TPA CERTIFIED) AND PRESCRIPTION EYEWEAR ONLY.

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____

REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription
THEY, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PERMISSIBLE BY LAW

Optometrists (without eyewear box)

Contact Lens Warning

CUSTOM IMPRINT OR INSTRUCTIONS

How did you hear about us?

Internet Search Associate Referral Email Mail Ad Facebook

Other _____

FORM TYPE: Please Check One (Prices subject to change without notice)

1-Part Pads – Single Sided (100 blanks per pad)

- 5 pads \$84.00 10 pads \$102.00 20 pads \$139.00 40 pads \$239.00 50 pads \$269.00 100 pads \$525.00

1-Part Pads with Alternate Address – 2 Sided (100 blanks per pad)

- 5 pads \$123.00 10 pads \$149.00 20 pads \$219.00 40 pads \$336.00

2-Part Carbonless Pads (50 blanks per pad)

- 10 pads \$139.00 20 pads \$199.00 40 pads \$270.00 80 pads \$455.00

2-Part Carbonless Pads with Alternate Address – 2 Sided (50 blanks per pad)

- 10 pads \$196.00 20 pads \$248.00 40 pads \$379.00 80 pads \$661.00

Please call for larger quantity pricing

SHIPPING COSTS

costs are in addition to printing charges – call for pricing

Custom Imprinting of Prescription Pads - Specific Information or Warnings In Text Area of Pad Add \$35.00

1 Sided Laser Forms on 8.5 x 11 Sheets

- 250 Sheets \$129.00 500 Sheets \$166.00 1000 Sheets \$225.00 2000 Sheets \$359.00 4000 Sheets \$569.00 5000 Sheets \$730.00

2 Sided Laser Forms on 8.5 x 11 Sheets

- 250 Sheets \$175.00 500 Sheets \$239.00 1000 Sheets \$339.00 2000 Sheets \$569.00 4000 Sheets \$956.00 5000 Sheets \$1199.00

Information to be printed on Prescription Blank:

1. Practice or Facility Name (optional if to be printed): _____
2. Practice or Specialty (only if to be printed below prescriber name): _____
3. Address to be printed on front: _____

4. Telephone: _____ 5. Fax: _____

PRESCRIBING DOCTOR OR APN · PA · CNM:

Prescriber Name: _____ Degree: _____
 Lic #: _____ NPI #: _____
 Dea # _____ Signature: _____

Additional Prescribers or Collaborating Dr. for APN · PA · CNM:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ | <ol style="list-style-type: none"> 2. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ |
| <ol style="list-style-type: none"> 3. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ | <ol style="list-style-type: none"> 4. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ |
| <ol style="list-style-type: none"> 5. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ | <ol style="list-style-type: none"> 6. Prescriber Name: _____
License #: _____ Degree: _____
DEA #: _____ NPI #: _____
*Prescriber Signature: _____ |

OPTIONAL: Additional addresses to be printed on the back of prescription blanks (must include phone number):
If additional addresses are required, attach separate sheet (up to 4 addresses).

Street: _____
 City, State, Zip: _____
 Phone: () _____

Street: _____
 City, State, Zip: _____
 Phone: () _____



Phone: 201.670.9797
Fax: 201.670.9798
Email: rx@ridgewoodpress.com

**This credit agreement must be completed and returned with
your order forms in order to process your order**



**CREDIT CARD CHARGE
AUTHORIZATION AGREEMENT**

I, _____, the holder of (check one, please):

VISA

MasterCard

American Express

Discover

Card Number: _____, Expiration Date: ____/____

3 digit code that is on the back of your Visa, MasterCard, Discover, or 4 digit code on the front of
your American Express Card _____.

I hereby authorize R. Press, Inc., as the parent company of Ridgewood Press.com, to charge my credit card for any invoice related to this order. With any RX Pad order a Non-Refundable \$50.00 deposit will be charged to this credit card when the order is placed and the 1st proof has been sent via email or fax. I agree not to chargeback Ridgewood Press.com once this proof has been sent. This \$50.00 deposit will go towards the total cost of my order. Once the proof is approved, R. Press, Inc. will process and ship the RX Pad order via UPS to the doctor's registered NJ State license address (required by law) **and a signature is required at time of delivery.** I also authorize Ridgewood Press.com to charge the above card for these shipping charges. I have read this agreement and understand that I will be held fully responsible for its terms and charges and agree not to chargeback Ridgewood Press.com if order is cancelled.

Cardholder: _____

Signature: _____

Company: _____

Mailing Address of Card: _____

City, State, Zip of Card: _____

Telephone: (_____) _____

Date: _____ / _____ / _____

**Please scan this completed form and email to: rx@ridgewoodpress.com
Or
Fax this form to our RX Dept: 201.670.9798**