Order form including health questionnaire

Delivery date

Patient details

The information marked with * must be provided.

First name*
Nachname*
Address*
ZIP*
City*
E-mail
Phone*
Newsletter yes no
Gender male female
Size (cm)*
Day of birth*
Weight (kg)*

Insurance data (Please complete or enclose a copy of your insurance card)

Basic insurance*
Card number* 80756
Insured person no.*
Suppl. insurance*
Card number* 80756
Insured person no.*

I agree that I will be supplied with a cheaper
generic instead of the original* yes no only after consultation with me

Delivery address (only if it differs from the patient address)

First name
Last name
Address
ZIP/City

Your health details

In order to be able to provide you with the best possible advice on drug therapy and to identify drug and health-related problems, we ask you to provide us with further data on your state of health and your medication. The information will only be processed within the scope of the information on the storage of medicinal product-related data for participation in the mail-order business with medicinal products in pharmacies (see FO 11.01.00.1). Please answer the questions truthfully.

Do you suffer from one of the following illnesses?*

Diabetes
High blood pressure
Blood clotting disorders
Bronchial asthma
Cardiovascular diseases
Liver diseases
Kidney diseases
Other diseases:

Which prescription and non-prescription medicines do you take regularly (name, strength, dosage)?*
(e.g. Aspirin cardio, 100mg, 1x1)

We are happy to help you with the preparation of the medicines.
If you have any questions or queries, we will contact you by telephone. Yes, please call back

Are there any intolerances or allergies?*
No Yes, which ones?

I agree that my doctor may send the medical prescription directly to Einsiedler Apotheke Drogerie*
yes no only after consultation with me

Questions about pregnancy and breastfeeding

Are you pregnant? yes no If „yes", expected date of birth
Breastfeed? yes no

I have read and agree to the business and data protection regulations (www.drogeriemoll.ch/agb)

Date*
Signature*
(legal representative, if applicable)

Send this form together with your original prescription to:
Drogerie Moll AG, Einkaufszentrum Zugerland, 6312 Steinhausen
If you have any questions, we will be happy to help you on 041 741 70 00 or info@drogeriemoll.ch