

PATIENT FAX ORDER FORM

Fax this order form to: (619) 758-1431

Please Print

Patient Name: _____ Phone: _____

Patient Address: _____ Date: _____

Physician Name: _____

PHYSICIANS: PHOTOCOPY THIS FORM AND PROVIDE TO PATIENTS

Product Requested

Catalog Number	Product	Size	Patient price each
<input type="checkbox"/> SEG04	ScarEase Gel	4 Gram Tube	\$15.00
<input type="checkbox"/> SEG15	ScarEase Gel	15 Gram Tube	\$30.00

Delivery Information

Please check one

- 2-3 day U.S. Postal Service delivery is free
- Overnight Domestic delivery add \$15.00

Payment

Please check one _____

- Visa
- Mastercard
- American Express

Or, enclose a check or money order
and mail with this form:

Scarease, Inc
P.O. Box 87521
San Diego, CA 92138-7521

Name on card

Card Number

Expiration Date

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