

Patient name: (please print) : _____

Prescription Medication List

We have an increasing number of patients taking multiple prescription medications, some of which may affect your dental health, or interact with medications that we use or may prescribe.

In the interest of your health care, please list ALL prescription medications that you are taking.

Medication:

Reason:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient (guardian) signature: _____ Date: _____

Updated: _____

Initials: _____

Updated: _____

Initials: _____

Updated: _____

Initials: _____

Updated: _____

Initials: _____