Merrimack Dental Associates

Prescription Medication List

Patient Name:_____ Birthdate:_____

Physician's Name:_____ Office:_____

Medical Specialist's Name:_____ Office:_____

Please list all medication(s). This INCLUDES vitamins, herbal supplements and over the counter non-prescription medicine.

Medication:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or Guardian Signature:_____ Date:_____

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