



Prescription Medication List

Patient Name: _____ Birthdate: _____

Physician's Name: _____ Office Location: _____

Medical Specialist's Name: _____ Office Location: _____

In the event of a medical emergency in our office please list a person we can contact on your behalf.

Name: _____ Phone: _____ Relationship: _____

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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Phone: 603-424-6131

Fax: 603-424-3620