Patient name: (please print) :_____ Birthdate: _____

Name of your Physician:_____

Medical specialist's name, if under current care:_____

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:_____Date:_____

Updated: _____Initials:_____ Updated:_____Date:_____

Updated:_____ Initials:_____ Updated:_____Date:_____