

# DENTAL

**MR Compounding Pharmacy**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Allergies: \_\_\_\_\_

**PLEASE CHECK THE APPROPRIATE BOXES:**

COMPOUND, STRENGTH, AND DIRECTIONS	QTY	REFILLS	PRICE
<input type="checkbox"/> Chloral hydrate 500 mg / 5 mL oral suspension Directions:			
<input type="checkbox"/> Hydroxyzine 10 mg/mL suspension Directions:			
<input type="checkbox"/> Any strength, any combination Lidocaine / Phenylephrine / Prilocaine / Benzocaine / Tetracaine Directions:			

**PROVIDER INFORMATION:**

Name: \_\_\_\_\_

Practice: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_