PRESCRIPTION

TOPICAL ANESTHETICS FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

MEDICATIONS

☐ Benzocaine _____ %

☐ Lidocaine _____ %

☐ Tetracaine _____ %

☐ Prilocaine _____ %

◯ Topical Plasticized Oinment

◯ Topical Gel

◯ Topical Occlusaderm

◯ Topical Cream

◯ Lipoderm

◯ Dental Gel

☐ Add DMSO _____ %

☐ Add Phenylephrine 0.01 %

PEDIATRIC

☐ Lidocaine 4 %

☐ Tetracaine 0.5 %

☐ Epinephrine 0.05 %

◯ Topical Gel

◯ Topical Spray

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____