DENTAL

Prescriber:		Patient:	D.O.B.:
Address:		Mobile Phone:	Home Phone:
City:	State: Zip:	Address:	
Phone:	Fax:	City:	State: Zip:
DEA:	NPI:	Allergies:	

GEL

	SIG: Apply _____ mL	Choose Qty:
☐ **Dental Anesthetic Gel** Lidocaine 10%, Prilocaine 10%, Tetracaine 4%	☐ BID	☐ 30gm
☐ **Dental Anesthetic Gel Thickened** **Lidocaine 10%, Prilocaine 10%, Tetracaine 4%**	☐ QDAY	**Refills:**
☐ **Dental Anesthetic Gel w/ Phenylephrine** Lidocaine 10%, Prilocaine 10%, Tetracaine 4%, Phenylephrine 2%	☐ PRN	**Flavors:**
	Other:	☐ Mint (dye-free)
		☐ Strawberry (dye-free)

Custom Formula:

PRESCRIBER:

Signature:_____ Date: ☐☐☐

Fax to the Pharmacy at 888-560-6691 or 940-382-2694.