



Email Prescriptions to: orders@medmixnow.com

Fax: (323) 851-4445

Phone: (323) 851-4444

medmixnow.com

PATIENT

Name:		DOB:
Street Address:		
City:	State:	Zip:
Phone:	Email:	
Medication Allergies:		

FORMULATIONS

	Size	
<input type="checkbox"/> Lidocaine 10%, Prilocaine 10%, Tetracaine 4% (Profound) <input type="checkbox"/> Mint <input type="checkbox"/> Strawberry <input type="checkbox"/> Grape <input type="checkbox"/> Blueberry <input type="checkbox"/> Bubblegum <input type="checkbox"/> Add Phenylephrine 2%	<input type="checkbox"/> 10mL Gel	<input type="checkbox"/> 10g Ointment
<input type="checkbox"/> Lidocaine 5%, Prilocaine 5%, Tetracaine 2% (Profound Lite) <input type="checkbox"/> Mint <input type="checkbox"/> Strawberry <input type="checkbox"/> Grape <input type="checkbox"/> Blueberry <input type="checkbox"/> Bubblegum <input type="checkbox"/> Add Phenylephrine 2%	<input type="checkbox"/> 10mL Gel	<input type="checkbox"/> 10g Ointment
<input type="checkbox"/> Lidocaine 20%, Tetracaine 4%, Phenylephrine 2% (TAC 20) <input type="checkbox"/> Mint <input type="checkbox"/> Strawberry <input type="checkbox"/> Grape <input type="checkbox"/> Blueberry <input type="checkbox"/> Bubblegum	<input type="checkbox"/> 10mL Gel	<input type="checkbox"/> 10g Ointment
<input type="checkbox"/> Lidocaine 12.5%, Tetracaine 12.5%, Prilocaine 3%, Phenylephrine 3% (Topical 12.5 or The Baddest Topical in Town) <input type="checkbox"/> Mint <input type="checkbox"/> Strawberry <input type="checkbox"/> Grape <input type="checkbox"/> Blueberry <input type="checkbox"/> Bubblegum	<input type="checkbox"/> 10mL Gel	<input type="checkbox"/> 10g Ointment
<input type="checkbox"/> Lidocaine 1%, Diphenhydramine 1% Rinse <input type="checkbox"/> Lidocaine 2%	8oz (240mL) bottle	
Directions (Required): <input type="checkbox"/> To be applied by dentist prior to oral procedure. Alternate Directions:		
Quantity of Prescriptions Checked: <input type="checkbox"/> 1 <input type="checkbox"/> 2 (Required)		

PRESCRIBER

Name:		Phone:
Street Address:		
City:	State:	Zip:
Fax:	Email:	
State License #:	NPI #:	DEA #:

Prescriber Signature: _____

Date: _____