



RX FORM

Fax: (323) 851-4445
 Phone: (323) 851-4444
 medmixnow.com

PATIENT

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

FORMULATIONS	Form	Qty
<input type="checkbox"/> Chlorhexidine Gel <input type="checkbox"/> 1% <input type="checkbox"/> 2%	Gel	<input type="checkbox"/> 30g <input type="checkbox"/> 60g
Directions:		
<input type="checkbox"/> Doxycycline 50mg/mL Gel	Gel	<input type="checkbox"/> 30 g <input type="checkbox"/> 60 g
Directions:		
<input type="checkbox"/> Minocycline Gel Kit Syringe 1: Minocycline 2% Powder Syringe 2: Mucoadhesive Gel	Gel	<input type="checkbox"/> 1 kit <input type="checkbox"/> 2 kits <input type="checkbox"/> 3 kits
Directions:		
<input type="checkbox"/> Minocycline 2% Paste (ready-to-use 1 mL syringes)	Paste	<input type="checkbox"/> 25mL
Directions:		

PRESCRIBER

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

Prescriber Signature: _____ Date: _____