Date: _____ Patient Name: _____
DOB: _____**Address:** _____
City: _____State: _____ Zip: _____ Phone: _____ Allergies: _____
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

DENTAL COMPOUNDS

☐ **Benzocaine/Eugenol/Ibuprofen Dressing 9.2%/7.27%/5% Ointment** #50grams or _____**gm**
Sig: Apply to affected area as directed or _____

☐ **Tetracaine 1% Lollipop** #10 Lollipops or_____ Sig: Suck on lollipop for 5-15 seconds only. Limit to no more than 3 times per hour. Return lollipop to child resistant container after each use.

☐ **Lidocaine 10%/Prilocaine 10%/Tetracaine 4% Gel** #_____**gm** Sig: AAA PRN or_____

☐ **Dyclonine 1% Oral Rinse** #_____**ml** Sig: Rinse mouth with 30ml for 1 minute then spit out.

☐ **Hydrogen Peroxide 10% Oral Gel** #90grams Sig: Apply to PerioProtect Trays UD.

☐ **Triamcinolone 0.1%/Lidocaine 2% Oral Rinse** #120ml Sig: Swish and Spit 5ml QID.

☐ **Fluocinonide 0.025% or Triamcinolone 0.1% or Dexamethasone 0.05% with Lidocaine 2% in Plasticized Base** #30grams
Sig: AAA 4 to 6 times daily for up to 1 week

☐ **Fluocinonide Ointment 0.05%/Orabase (with benzocaine 20%) 50/50**#20 grams Sig: AAA up to 6 times daily for up to 1 week.

☐ **Triamcinolone 0.1% in Orabase (with benzocaine 20%)** #20 grams Sig: AAA up to 6 times daily for up to 1 week.

☐ **Clonazepam 1mg Troche** #30 Sig: Dissolve 1/2 to 1 troche slowly on tongue up to QID PRN.

☐ **Nystatin (Sugar Free) 100,000 U/ml Oral Rinse** #60ml Sig: Swish and spit 5ml in mouth QID for 14 days.

☐ **Nystatin 200,000 Unit Troche** #30 Sig: Dissolve 1 troche slowly in mouth QID PRN.

☐ **Clotrimazole 100mg/Ibuprofen 10mg Troche** #30 Sig: Dissolve 1 troche slowly in mouth QID PRN x 7-14 days.

☐ **Acyclovir 5%/Lidocaine 1%/ Lipbalm** #5grams (1 tube) Sig: AAA PRN.

☐ **Ketoprofen 5% Oral Gel** #30grams Sig: AAA QID PRN.

☐ **Ketoprofen 20%/Cyclobenzaprine 3%/Lidocaine 2% Lipoderm Cream** #30grams Sig: AAA BID to QID PRN.

☐ **SUCK-CESS 2% (Sucrose Octaacetate Gel)** #10 grams (1 tube) Sig: AAA PRN.

_____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: _____ Agent sending fax: _____

Clinic Name: _____
Clinic Address: _____
Clinic Phone/Fax: _____