Date: ____________ **Patient Name**: ____
DOB: _____________**Address:** ____
City: _____________**State:** ______ **Phone:** ____________ **Allergies:** _________________
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Chlorophyllin Sodium Copper 0.2% Mouthwash (MucoLox™)**
Qty: #90 ml
Sig: Swish and spit 3 ml three times daily as needed.
Or: ____

☐ **Green Tea Extract 5% Mouth Rinse (MucoLox™)**
Qty: #90 ml
Sig: Swish and spit 3 ml three times daily as needed.
Or: ____

☐ **Mouthwash with Natural Flavors (MucoLox™)**
Qty: #90 ml
Sig: Swish and spit 3 ml three times daily as needed.
Or: ____

____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: ______________________________________ **Agent sending**: _____________________________
NPI: ____ **DEA**: ______________________________________

Clinic Name: ____
Clinic Address: ____
Clinic Phone/Fax: ______________________________________