EAST TAYLOR DENTAL, P.C. – PATIENT MEDICATION LIST

PATIENT NAME: _____**ACCT #**_____**DATE:** _____

Prescription Medications (Include Vitamins, Herbs & Over the Counter Medications)	**Prescribed Dosage**	**Frequency & When Taken** (AM/Noon/PM)	**Name of Prescribing Doctor**	**Condition or Reason for taking Medication**	**For Office Use Only**
Ex: Nexium	40mg	One dose per day @ bedtime	Dr. Feel Good	Peptic Ulcer	

To the best of my knowledge, the above listed medications etc. are accurate for this patient. I understand that providing incorrect information can be dangerous to this patient's health. Signature of Patient or Parent of Patient: _____

(If medications extend beyond this page, please complete a second form)