APOTHECARY OPTIONS

Prescription Order Form

Patient Name: _____**Date**: _____

Address: _____**Date of Birth**: _____

City: _____**State**: _____ **Zip**: _____ **Allergies**: _____

Day Phone: (_____) _____ **Evening Phone**: (_____) _____

Laser / Electrolysis Numbing Cream

(Benzocaine 20%, Lidocaine 6%, Tetracaine 4% in a liposomal delivery vehicle)

- ❑ 15gm
- ❑ 30gm
- ❑ 60gm

Refill PRN

Sig: Apply to skin area 30-45 minutes prior to procedure as prescribed. Read product information sheet carefully prior to use.

Prescriber Signature: _____

Prescriber Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

State License: _____**DEA**: _____

Phone: (_____) _____ **Fax**: (_____) _____

Instructions:

- **Complete <u>all</u> sections.**
- **We must verify the legitimacy of all prescriptions as required by law.**
- **We will contact you to arrange for payment and shipping.**
- **Fax or mail the completed prescription to:**

APOTHECARY OPTIONS
3006 Esplanade, Suite I, Chico, CA 95973
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