



Prescription Order Form

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: _____ Phone: (____) _____

<input type="checkbox"/> Zinc + SSD + Aquaphor (1:1:1)- Mix	Sig: _____	Qty 60gm	Refill _____
<input type="checkbox"/> Azelaic Acid 15% Topical Gel	Sig: _____	Qty 60gm	Refill _____
<input type="checkbox"/> Hydroquinone _____ % Retinoic Acid _____ %	Steroid: <input type="checkbox"/> Desonide 0.05% <input type="checkbox"/> Hydrocortisone 0.5%	Sig: _____	Qty 30gm _____ Refill _____
<input type="checkbox"/> Hydroquinone _____ % Kojic Acid _____ %	Steroid: <input type="checkbox"/> Desonide 0.05% <input type="checkbox"/> Hydrocortisone 0.5%	Sig: _____	Qty 30gm _____ Refill _____
<input type="checkbox"/> Fluconazole 2% + Itraconazole 1% + Ibuprofen 2% in DMSO Nail Solution	Sig: Place 1 drop twice daily to affected nail(s)	Qty: 30ml	Refill _____
<input type="checkbox"/> Triamcinolone 0.1% in Propylene Glycol- Lotion	Sig: _____	Qty 240ml	Refill _____
<input type="checkbox"/> LCD 10% in Aquaphor Check here <input type="checkbox"/> to add Triamcinolone 0.1%	Sig: _____	Qty 100gm	Refill _____
<input type="checkbox"/> Benzocaine 20%, Lidocaine 6%, Tetracaine 4%- Water Based Cream	Sig: _____	Qty 30gm _____	Refill _____

Prescriber Signature: _____ Today Date: _____

Prescriber Printed Name: _____ MD DO ND PA NP CNM/CN

State License: _____ DEA: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____