

UNIVERSITY ORAL SURGERY CENTER
Prescription Request Form

Please fill out the following information completely and legibly for prescriptions. According to state regulations, we can only submit prescriptions electronically to a designated pharmacy. In case your pharmacy does not carry the prescribed medication(s), prescriptions may be transferred, or a new prescription may need to be submitted to another pharmacy. This information may be used for future prescriptions if necessary, unless we are informed otherwise.

Patient's Name: _____ () Male () Female

Patient's Address: _____ Apt. _____
City _____ State _____ Zip _____

Patient's date of birth: _____

Phone number: _____ () Mobile () Home

Pharmacy name: _____

Pharmacy Address: _____
City _____ State _____ Zip code _____

Pharmacy phone number: _____